

SERFF Tracking Number: FORT-125773055 State: Arkansas
 Filing Company: Fortress Insurance Company State Tracking Number: EFT \$100
 Company Tracking Number: FD-AR-F1-0109
 TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0030 Dentists
 Made/Occurrence
 Product Name: Fortress Dental Professional Liability
 Project Name/Number: Amend Part-Time Endorsements/FD-AR-F1-0109

Filing at a Glance

Company: Fortress Insurance Company
 Product Name: Fortress Dental Professional Liability SERFF Tr Num: FORT-125773055 State: Arkansas
 TOI: 11.0 Medical Malpractice - Claims SERFF Status: Closed State Tr Num: EFT \$100
 Made/Occurrence
 Sub-TOI: 11.0030 Dentists Co Tr Num: FD-AR-F1-0109 State Status: Fees verified and received
 Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Edith Roberts
 Author: Mary Frisone Disposition Date: 09/08/2008
 Date Submitted: 08/12/2008 Disposition Status: Approved
 Effective Date Requested (New): 01/01/2009 Effective Date (New):
 Effective Date Requested (Renewal): 01/01/2009 Effective Date (Renewal):
 State Filing Description:

General Information

Project Name: Amend Part-Time Endorsements Status of Filing in Domicile: Pending
 Project Number: FD-AR-F1-0109 Domicile Status Comments: none at this time
 Reference Organization: n/a Reference Number: n/a
 Reference Title: n/a Advisory Org. Circular: n/a
 Filing Status Changed: 09/08/2008
 State Status Changed: 09/08/2008 Deemer Date:
 Corresponding Filing Tracking Number:
 Filing Description:
 We are amending the two endorsements listed on the Form Filing Schedule. The companion rate/rule filing is FD-AR-R1-0109. In these two Part-Time Endorsements we are increasing the number of hours permitted for the endorsement to be in effect - from "16 hours per week or 800 hours per year" to "20 hours per week or 1,000 hours per year." In addition, we withdraw one form which we have not issued to any policy to date, nor do we intend to issue it.

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Please note that this filing also applies to Sub-TOI 11.0006 Dentists - General Practice. There does not seem to be a way to choose both.

Company and Contact

Filing Contact Information

Mary Frisone, Sr. Compliance Analyst mary.frisone@fortressins.com
 6133 N. River Road (847) 653-8823 [Phone]
 Rosemont, IL 60018 (847) 653-8843[FAX]

Filing Company Information

Fortress Insurance Company CoCode: 10801 State of Domicile: Illinois
 6133 N. River Road Group Code: 508 Company Type: Property & Casualty
 Suite 650
 Rosemont, IL 60018 Group Name: The National Group State ID Number:
 (847) 384-0062 ext. [Phone] FEIN Number: 36-4159841

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: Illinois filing fee is \$50 per form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fortress Insurance Company	\$100.00	08/12/2008	21908851

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	09/08/2008	09/08/2008

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Part-Time Coverage	Approved	Yes
Form	Part-Time Coverage During Active Duty Military Service	Approved	Yes
Form	Prior Acts Deductible	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Part-Time Coverage	FD1002	0109	Endorsement/Amendment/Conditions Replaced	Replaced Form #: FD1002 (01/03) Previous Filing #:		FD1002 0109.pdf
Approved	Part-Time Coverage During Active Duty Military Service	FD1039	0109	Endorsement/Amendment/Conditions Replaced	Replaced Form #: FD1039 (01/03) Previous Filing #:		FD1039 0109.pdf
Approved	Prior Acts Deductible	FD1062	(02/03)	Endorsement/Amendment/Conditions Withdrawn	Replaced Form #: Previous Filing #:		

ENDORSEMENT FOR PART-TIME COVERAGE

We issue this Endorsement in reliance upon **your** written representation as stated in the paragraph checked below:

Your private practice of **dentistry** is conducted part-time, with all of **your** practice activities, such as office hours, hospital rounds, patient visits, dental procedures, consultations, record keeping and correspondence carried out, on the average, not more than 20 hours per week or 1,000 hours per year. It is a condition to **your** protection by this Policy that **you** continue to conduct **your** practice on a part-time basis, not exceeding an average of 20 hours per week or 1,000 hours per year while this Endorsement is in effect.

You are engaged in the practice of **dentistry** as the employee of the government agency, educational institution, residency program or health care facility, identified below, which provides professional liability insurance or similar protection for **your** practice as its employee, and **your** private practice of **dentistry** is conducted part-time, with all of **your** practice activities, such as office hours, hospital rounds, patient visits, **dental** procedures, consultations, record keeping and correspondence carried out, on the average, not more than 20 hours per week or 1,000 hours per year. It is a condition to **your** protection by this Policy that **you** continue to be engaged in practice as the employee of the government agency, educational institution, residency program or health care facility identified below, which provides professional liability insurance or other similar protection for **your** practice as its employee and to otherwise conduct **your** private practice on a part-time basis, not exceeding an average of 20 hours per week or 1,000 hours per year while this Endorsement is in effect. **We** will not pay or defend against any liability arising out of care **you** provided as the employee of the government agency, educational institution, residency program, or health care facility identified below.

Government agency, educational institution, residency program or health care facility employing **you**:

Policy Number:
Effective: 12:01 A.M.,
Issued to:
FD1002 0109

You are enrolled in a bona fide training program, that all of **your** professional activities in such training program are subject to other professional liability insurance or similar protection; that all of **your** professional activities in such training program are not protected by this Policy; and **your** private practice or employed practice of **dentistry** protected by this Policy is conducted part-time, with all of **your** practice activities such as office hours, hospital rounds, patient visits, **dental** procedures, consultations, record keeping and correspondence carried out, on the average, not more than 20 hours per week or 1,000 hours per year. It is a condition to **your** protection by the Policy that **you** continue to be enrolled in a bona fide training program subject to other professional liability insurance or similar protection and that **you** continue to conduct **your** private or employed practice protected by this Policy on a part-time basis, not exceeding an average of 20 hours per week or 1,000 hours per year while this Endorsement is in effect. **We** will not pay or defend against any claim arising out of care **you** provided or should have provided in connection with such bona fide training program.

By accepting this Endorsement, **you** agree that **we** do rely on **your** representation in issuing this Endorsement and reducing **your** premium; that it is reasonable for **us** to rely on **your** representation; and that **your** representation is material to **our** agreement to issue this Endorsement and reduce **your** premium.

Total Return Premium: \$.00

In consideration of the premium, and the mutual agreements of the **protected parties** and **us**, the Policy identified below, of which this Endorsement is a part, is changed as stated above.

All other terms and conditions of this Policy not specifically changed by this Endorsement shall remain the same.

Name

Title

Signature

Policy Number:
 Effective: 12:01 A.M.,
 Issued to:
 FD1002 0109



**ENDORSEMENT FOR PART-TIME COVERAGE DURING
ACTIVE DUTY MILITARY SERVICE**

This Endorsement is issued by **us** in reliance upon **your** written representation that **you** have been called up for service on active duty status as a member of one of the branches of the Armed Forces Reserves of the United States, and that while **you** are on active duty, from the effective date of this Endorsement, **your** private practice of **dentistry** is conducted part-time, with all of **your** private practice activities, such as office hours, hospital rounds, patient visits, **dental** procedures, consultations, record keeping and correspondence carried out in no more than 20 hours per week.

By accepting this Endorsement, **you** agree that **we** do rely on **your** representation in issuing this Endorsement and reducing **your** premium; that it is reasonable for **us** to rely on **your** representation; and that **your** representation is material to **our** agreement to issue this Endorsement and reduce **your** premium.

It is a condition to **your** protection by this Policy that **your** private practice is conducted part-time, with all of **your** private practice activities, such as office hours, hospital rounds, patient visits, **dental** procedures, consultations, record keeping and correspondence carried out in no more than 20 hours per week while this Endorsement is in effect.

We will not pay or defend against any **claim** arising out of any care **you** provided or should have provided while serving on active duty status as a member of one of the branches of the Armed Forces Reserves of the United States except care **you** provided or should have provided in **your** part-time practice not exceeding 20 hours per week.

Upon written notice to **us**, within thirty- (30) days after **your** discharge from active duty and return to private practice, accompanied by copies of **your** orders or equivalent documents confirming **your** time of active duty status, **we** will issue a further Endorsement providing that this Policy is again fully effective as to all otherwise covered **claims**, except for **claims** arising out of care **you** provided or should have provided as a member of the Armed Forces Reserves of the United States during the period of **your** active duty service.

Total Return Premium: \$<Fill In>

In consideration of the additional premium, and the mutual agreements of the **protected parties** and **us**, the Policy identified below, of which this Endorsement is a part, is changed as stated above.

All other terms and conditions of this Policy not specifically changed by this Endorsement shall remain the same.

Name

Title

Signature

Policy Number:
Effective: 12:01 A.M.,
Issued to:
FD1039 0109

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status: Approved 09/08/2008

Comments:
Attachment:
industry_rates_PCtransDoc_intelligentForms.pdf

Property & Casualty Transmittal Document

<p>1. Reserved for Insurance Dept. Use Only</p>	<p>2. Insurance Department Use only</p> <p>a. Date the filing is received:</p> <p>b. Analyst:</p> <p>c. Disposition:</p> <p>d. Date of disposition of the filing:</p> <p>e. Effective date of filing:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">New Business</td> <td></td> </tr> <tr> <td>Renewal Business</td> <td></td> </tr> </table> <p>f. State Filing #:</p> <p>g. SERFF Filing #:</p> <p>h. Subject Codes</p>	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #
The National Group	0508

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #

5. Company Tracking Number	
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail

7. Signature of authorized filer	
8. Please print name of authorized filer	

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	
10. Sub-Type of Insurance (Sub-TOI)	
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: <input type="text"/> Renewal: <input type="text"/>
15. Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

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FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	
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2.	This filing corresponds to form filing number (Company tracking number of form filing, if applicable)	
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Rate Increase
 Rate Decrease
 Rate Neutral (0%)

3.	Filing Method (Prior Approval, File & Use, Flex Band, etc.)	
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4a.	Rate Change by Company (As Proposed)
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b.	Rate Change by Company (As Accepted) For State Use Only
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Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5.	Overall Rate Information (Complete for Multiple Company Filings only)
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		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
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7.	Effective Date of last rate revision	
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8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	
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9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
02		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	
03		<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	