

SERFF Tracking Number: MDPC-125887413 State: Arkansas  
Filing Company: The Medical Protective Company State Tracking Number: EFT \$50  
Company Tracking Number: 08-DA-01  
TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations  
Made/Occurrence  
Product Name: Dentists  
Project Name/Number: Dentists Application Filing/08-DA-01

## Filing at a Glance

Company: The Medical Protective Company

Product Name: Dentists

TOI: 11.0 Medical Malpractice - Claims

Made/Occurrence

Sub-TOI: 11.0000 Med Mal Sub-TOI

Combinations

Filing Type: Form

SERFF Tr Num: MDPC-125887413 State: Arkansas

SERFF Status: Closed

State Tr Num: EFT \$50

Co Tr Num: 08-DA-01

State Status: Fees verified and received

Co Status:

Reviewer(s): Edith Roberts, Brittany Yielding

Author: Melissa Coker

Disposition Date: 01/09/2009

Date Submitted: 11/05/2008

Disposition Status: Approved

Effective Date Requested (New): 04/01/2009

Effective Date (New):

Effective Date Requested (Renewal): 04/01/2009

Effective Date (Renewal):

State Filing Description:

## General Information

Project Name: Dentists Application Filing

Project Number: 08-DA-01

Reference Organization: n/a

Reference Title: n/a

Filing Status Changed: 01/09/2009

State Status Changed: 01/09/2009

Corresponding Filing Tracking Number:

Filing Description:

The Medical Protective Company is pleased to submit for your review and approval, new applications specific to our Dentists Programs. We request an effective date of April 1, 2009.

Status of Filing in Domicile: Pending

Domicile Status Comments: Currently pending in the state of Indiana.

Reference Number: n/a

Advisory Org. Circular: n/a

Deemer Date:

SERFF Tracking Number: MDPC-125887413 State: Arkansas  
 Filing Company: The Medical Protective Company State Tracking Number: EFT \$50  
 Company Tracking Number: 08-DA-01  
 TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations  
 Made/Occurrence  
 Product Name: Dentists  
 Project Name/Number: Dentists Application Filing/08-DA-01

## Company and Contact

### Filing Contact Information

Melissa Coker, Paralegal melissa.coker@medpro.com  
 5814 Reed Road (260) 486-0838 [Phone]  
 Fort Wayne, IN 46835 (260) 486-0733[FAX]

### Filing Company Information

The Medical Protective Company	CoCode: 11843	State of Domicile: Indiana
5814 Reed Road	Group Code:	Company Type:
Fort Wayne, IN 46835	Group Name:	State ID Number:
(260) 486-0838 ext. [Phone]	FEIN Number: 35-0506406	
	-----	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: 50.00 for form filings  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Medical Protective Company	\$50.00	11/05/2008	23715647

SERFF Tracking Number: MDPC-125887413      State: Arkansas  
 Filing Company: The Medical Protective Company      State Tracking Number: EFT \$50  
 Company Tracking Number: 08-DA-01  
 TOI: 11.0 Medical Malpractice - Claims      Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations  
       Made/Occurrence  
 Product Name: Dentists  
 Project Name/Number: Dentists Application Filing/08-DA-01

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	01/09/2009	01/09/2009

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
status of filing	Note To Reviewer	Melissa Coker	12/10/2008	12/10/2008



SERFF Tracking Number: MDPC-125887413 State: Arkansas  
 Filing Company: The Medical Protective Company State Tracking Number: EFT \$50  
 Company Tracking Number: 08-DA-01  
 TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations  
 Made/Occurrence  
 Product Name: Dentists  
 Project Name/Number: Dentists Application Filing/08-DA-01

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	listing of applications (memo)	Approved	Yes
Form	Dental Anesthesia Supplement	Approved	Yes
Form	Application-Student Dental Board Coverage	Approved	Yes
Form	Dental Entity Application	Approved	Yes
Form	Dental Loss Information Supplement	Approved	Yes
Form	Dental Non-Insured Supplement	Approved	Yes
Form	Dental Policy Change Request	Approved	Yes
Form	Dental New Graduate Application	Approved	Yes
Form	Dental Individual Application	Approved	Yes



SERFF Tracking Number: MDPC-125887413 State: Arkansas  
 Filing Company: The Medical Protective Company State Tracking Number: EFT \$50  
 Company Tracking Number: 08-DA-01  
 TOI: 11.0 Medical Malpractice - Claims Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations  
 Made/Occurrence  
 Product Name: Dentists  
 Project Name/Number: Dentists Application Filing/08-DA-01

## Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Dental Anesthesia Supplement	Dental Anesthesia-Supp-00	06/01/2008	Application/ New Binder/Enrollment		0.00	dental anesthesia supp 00 0608 edt.pdf
Approved	Application-Student Dental Board Coverage	DBA-0100-00	Edition Date: 02/08	Application/ New Binder/Enrollment		0.00	dental board app.pdf
Approved	Dental Entity Application	Dental-Entity-AR	06/01/2008	Application/ New Binder/Enrollment		0.00	dental-entity-ar.pdf
Approved	Dental Loss Information Supplement	Dental Loss Information - Supp-00	06/01/2008	Application/ New Binder/Enrollment		0.00	dental loss information supp 00 0608 edt.pdf
Approved	Dental Non-Insured Supplement	Non-Insured-Supp-00	06/01/08	Application/ New Binder/Enrollment		0.00	dental non insured supp 00- 0608 edt.pdf
Approved	Dental Policy Change Request	Dental-Change-00	06/01/08	Application/ New Binder/Enrollment		0.00	dental policy change request 00 0608 edt.pdf
Approved	Dental New Graduate Application	Dental-Grad-AR	06/01/08	Application/ New Binder/Enrollment		0.00	dental-grad-ar.pdf
Approved	Dental Individual Application	Dental-Indv-AR	06/01/2008	Application/ New Binder/Enrollment		0.00	dental-indv-ar.pdf

**DENTAL ANESTHESIA SUPPLEMENT**

Applicant's Name \_\_\_\_\_

A. If you perform conscious sedation and/or general anesthesia, do you administer sedation for medical procedures?  Yes  No

B. Please indicate who administers **Conscious Sedation**:

- I Do
- Oral Surgeon
- Nurse Anesthetist/CRNA
- Other (Please explain) \_\_\_\_\_
- RN/LPN
- Dental Anesthesiologist
- MD/DO Anesthesiologist

Where is **Conscious Sedation** performed?

- In My Office
- Hospital
- Licensed JCAHO or AAAHC Approved Surgical Center
- Other (Please explain) \_\_\_\_\_

C. Please indicate who administers **General Anesthesia**:

- I Do
- Oral Surgeon
- Nurse Anesthetist/CRNA
- Other (Please explain) \_\_\_\_\_
- RN/LPN
- Dental Anesthesiologist
- MD/DO Anesthesiologist

Where is **General Anesthesia** performed?

- In My Office
- Hospital
- Licensed JCAHO or AAAHC Approved Surgical Center
- Other (Please explain) \_\_\_\_\_

D. Do you accept referrals for the administration of anesthesia?  Yes  No

E. Do you prescribe Benzodiazepine type oral sedation agents? (Halcion, Triazolam, Ativan, Valium or similar anesthetic agent)  Yes  No

If yes, do you exceed the maximum recommended dosage ("MRD")?  Yes  No

If yes, are you trained and is your office prepared to administer reversal agents such as flumazenil intravenously?  Yes  No

F. How often do you update health histories?

Every:  3 Months  6 Months  12 Months  Other \_\_\_\_\_

G. Is your office certified for general anesthesia by a state organization?  Yes  No

If yes, date of issuance: (MM/YYYY) \_\_\_\_\_

H. If conscious sedation or general anesthesia is performed outside of a hospital, JCAHO or AAAHC approved facility, how often do you and your staff participate in simulated emergency training?

Every:  3 Months  6 Months  12 Months  Other \_\_\_\_\_

I. Are you or the individual administering the sedation, certified in one or more of the following?  Yes  No

If yes, please mark the applicable boxes:  CPR  ACLS  ATLS  PALS

J. Do you utilize the following equipment? (Please "X" equipment used)  
 Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital, JCAHO or AAAHC approved facility.

**Basic Airway Equipment:**

- Oral and Nasopharyngeal Airways
- Full Face Mask Resuscitator
- Endotracheal Tubes (adult/child size)
- Laryngoscope
- Direct Current Defibrillator
- Tracheostomy/Coniotomy Equipment
- Sphygmomanometer/Stethoscope
- Electrocardiographic Monitoring Equipment
- Pulse Oximeter
- CO2 Monitor
- Internal/External Temperature Monitor
- Portable Suction
- Capnography
- Auxillary Lighting
- Emergency Pharmaceutical Kit
- Fail safe mechanisms on anesthesia machines

K. If you are hosting anesthesia provider(s), outside of a hospital, JCAHO or AAAHC approved facility, have you and will you ensure those anesthesia provider(s) have:

The equipment indicated (checked) above?  Yes  No

Professional liability limits equal to or greater than your policy limits?  Yes  No

# Application - Student Dental Board Coverage

Please complete all information requested. Note: application must be received at least two weeks prior to exam date.

Please print

I. Name		Social Security No.		Date of Birth	
Mailing Address					
City		State		Zip	
Home Phone		Work Phone			
II. Forwarding address after graduation					
Street		City		St Zip	
Name of school		Graduation Date (MO/DAY/YR)			
Email Address					
III. Planned location of practice					
Street		City		St Zip	
IV.					
A. Have you ever been treated for alcoholism, narcotic addiction or mental illness?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Have you ever been charged or convicted of a felony? If Yes, give details:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Have you ever had any chronic illness or physical defect?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Have any claims or suit ever been filed against you as a result of professional service rendered? If Yes, give details, amounts paid, dates:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
E. Has this form of insurance or other similar insurance ever been cancelled, refused or nonrenewed? If Yes, give reason:				<input type="checkbox"/> Yes <input type="checkbox"/> No	

# The Medical Protective Company

Fort Wayne, Indiana

V. I will take the following examination(s):	
City of Examination: _____	
State of Examination: _____	
Examination Dates: From: _____ To: _____	
VI. Are you taking a specialty board exam? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, please identify specialty _____	
VII. Dental Board Professional Liability: \$1,000,000/\$3,000,000 limits	
I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I also acknowledge that if approved, coverage is only for services rendered during a dental internship prior to graduation and/or dental board examination pursuant to professional licensing.	
Signature _____	Date _____
Please Fax or E-Mail Application: 800-398-6726 / dental@medpro.com	
FOR COMPANY USE ONLY	
Dates of Coverage: From: _____ To: _____	
Date: _____ Acct: _____	Initials: _____

**DENTAL ENTITY APPLICATION**

**I. ORGANIZATION INFORMATION**

**A. Entity Name:**  
(As stated in the Articles of Incorporation and all formal Entity/Clinic Names. Failure to provide complete names may void coverage.)

Entity Name \_\_\_\_\_

DBA, Fictitious Name, etc. \_\_\_\_\_

Federal Tax I.D. Number \_\_\_\_\_ National Provider Identifier (NPI) \_\_\_\_\_

Date Entity Formed (MM/YYYY) \_\_\_\_\_

E-Mail \_\_\_\_\_ Business Fax \_\_\_\_\_ Business Phone \_\_\_\_\_

**B. If the above entity does business under any other name, please list all additional entity/clinic names.**

Entity Name \_\_\_\_\_

Federal Tax I.D. Number \_\_\_\_\_ National Provider Identifier (NPI) \_\_\_\_\_

Date Entity Formed (MM/YYYY) \_\_\_\_\_

- C. Type of Legal Entity:** (Please put an "X" in the applicable spaces.)
- |   |   |
|---|---|
| <input type="checkbox"/> Professional Corporation - sole shareholder  | <input type="checkbox"/> Limited Liability Corporation (LLC)    |
| <input type="checkbox"/> Shared Limit Coverage with my Medical Protective Individual Limits Policy<br>(No Employed or Contracted Dentist) | <input type="checkbox"/> General Business Corporation           |
| <input type="checkbox"/> Separate Entity Limits   | <input type="checkbox"/> Governmental (state, local or federal) |
| <input type="checkbox"/> Professional Corporation - multiple shareholders   | <input type="checkbox"/> Not-For-Profit Clinic                  |
| <input type="checkbox"/> Partnership or Professional Association  | <input type="checkbox"/> For-Profit Clinic                      |
| <input type="checkbox"/> Joint Venture  | <input type="checkbox"/> Other (Please explain) _____           |

- D. Type of Organization:** (Please put an "X" in the applicable spaces.)
- |  |  |
|--|--|
| <input type="checkbox"/> Private Practice Dental Office                          | <input type="checkbox"/> Licensed Dental Surgical Center |
| <input type="checkbox"/> Administrative, billing and management entity           | <input type="checkbox"/> JCAHO / AAAHC Approved          |
| <input type="checkbox"/> Dental School   | <input type="checkbox"/> Mobile Dental Practice          |
| <input type="checkbox"/> Managed Care Organization/Managed Services Organization | <input type="checkbox"/> Nursing Home Based Practice     |
| <input type="checkbox"/> Non Profit Clinic                                       | <input type="checkbox"/> Dental Laboratory               |
| <input type="checkbox"/> Governmental Clinic                                     | <input type="checkbox"/> Pharmacy                        |
| <input type="checkbox"/> Veterans Administration/Military Clinic                 | <input type="checkbox"/> Other (Please explain) _____    |
| <input type="checkbox"/> Prison/Penitentiary                                     |  |
| <input type="checkbox"/> Short Term Correctional Facility                        |  |

**E. Is this entity associated with a current Medical Protective insured?**  Yes  No  
(If yes, please provide the individual, corporation or partnership policy and group number if known.)

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

## I. ORGANIZATION INFORMATION (CONTINUED)

### F. Practice Location(s):

(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

#### 1. Primary Location:

% of Practice \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

#### 2. Additional Location:

% of Practice \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### G. In which state(s) is this entity authorized to do business?

State of Incorporation \_\_\_\_\_

Certificate(s) of Authority \_\_\_\_\_

### H. Preferred Billing and Correspondence Address:

Location Number \_\_\_\_\_ (From Section F. above)  Other (please enter below)

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## II. GENERAL INFORMATION

### A. Does the entity own or share ownership in a hospital, nursing home, clinic or other health care facility?

Yes  No

If yes, please explain \_\_\_\_\_

### B. Are you aware of any former employee(s):

1. Has ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association?

Yes  No

If yes, please provide the individual name(s), explanation and date(s).

Individual Name(s) \_\_\_\_\_ Explanation \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

2. Has ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, dental license, or Medicaid/Medicare privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?

Yes  No

If yes, please provide the individual name(s), explanation and date(s).

Individual Name(s) \_\_\_\_\_ Explanation \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

3. Has ever had any professional liability insurance refused, cancelled or non-renewed by an insurance company?

Yes  No

If yes, please provide the individual name(s), explanation and date(s).

Individual Name(s) \_\_\_\_\_ Explanation \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

## II. GENERAL INFORMATION (CONTINUED)

C. Does the entity use a collection agency which has the authority to file collection suits without your knowledge?  Yes  No

D. Does the entity own or operate any laboratory?  Yes  No

If yes, is the laboratory providing services solely for your patients?  Yes  No

If no, please explain \_\_\_\_\_

E. Will the entity be performing activities that will be covered by another professional liability policy?  Yes  No

If yes, state practice name, location and insurer name:

Practice Name \_\_\_\_\_

Location \_\_\_\_\_

Name of Insurer \_\_\_\_\_

F. Has the entity performed any contract work for or entered into any contract or agreement (written or oral) with any Entity/City/County/State/Federal Agency/Clinic including providing care at correctional facilities, prisons, mental health facilities, veterans administration, university, military, indigent care or children's clinics, etc.?  Yes  No

If yes, please explain \_\_\_\_\_

G. Is general anesthesia administered outside of a hospital, JCAHO or AAAHC approved facility?  Yes  No

If yes, please answer the following:

1. Is scheduled preventative maintenance performed on all biomedical equipment each year by a qualified biomedical technician?  Yes  No

If no, please explain \_\_\_\_\_

2. Does the entity have a dental services review committee?  Yes  No

If no, please explain \_\_\_\_\_

3. Does the recovery room provide full time observation by a qualified health care provider?  Yes  No

If no, please explain \_\_\_\_\_

## III. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit involving former or present partners, members of the corporation, and any former or present employee or independent contractor of the corporation, partnership or organization.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints, etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Is your organization or any of your employees/contractors involved now or have ever been involved in a claim or suit arising out of the rendering or failure to render professional services?  Yes  No

If yes, how many? \_\_\_\_\_

B. Is your organization or any of your employees/contractors aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes but is not limited to the following:  Yes  No

-Cancer

-Death

-Permanent Neurological Injury

-Permanent Nerve Injury

If yes, how many? \_\_\_\_\_

C. In the last 12 months, has your organization or any of your employees/contractors received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit?  Yes  No

If yes, how many? \_\_\_\_\_

## IV. ROSTER OF STAFFING INFORMATION

Please identify all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below.

	1. Last name first, then first name and middle initial (i.e. Smith, John G.)	2. Degree	3. Specialty #1-18 (Refer to Key below)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status A,B,C,D, or E (Refer to Key below)	6. Medical Protective Policy #
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						

Use the following key for:

**Specialty: (column 3)**

- |                                   |                            |   |
|-----------------------------------|----------------------------|---|
| 1. General Dentist                | 7. Endodontist             | 13. Office Manager                            |
| 2. Oral and Maxillofacial Surgeon | 8. Dental Anesthesiologist | 14. Dental Lab Technician                     |
| 3. Orthodontist                   | 9. Pain Management         | 15. Nurse Anesthetist / CRNA                  |
| 4. Pediatric Dentist              | 10. Physician              | 16. RN / LPN                                  |
| 5. Periodontist                   | 11. Dental Assistant       | 17. X-Ray Technician                          |
| 6. Prosthodontist                 | 12. Dental Hygienist       | 18. Other (Specify job desc. in section VIII) |

**Individual Status: (column 5)**

- A. Previous Individual Medical Protective Insured requesting Individual Medical Protective coverage.
- B. Current Individual Medical Protective Insured.
- C. Requesting Individual Medical Protective coverage.
- D. Applying for coverage elsewhere or covered elsewhere.
- E. Shared Limit Coverage - Including Allied Health Care Professionals.

**\*Note: Include all applicant(s), all healthcare provider(s) and non-healthcare owner(s).**

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by the Shared Limit Additional Insured Endorsement.

**\*\*If any of the Dentists who are corporation shareholders, employees and independent contractors listed on the roster above are not currently insured with Medical Protective, please complete the Non-Insured Supplement.**

## V. COVERAGE INFORMATION

### A. Coverage Desired:

- Occurrence
- Claims-Made coverage without Prior Acts coverage
- Claims-Made coverage with Prior Acts coverage
- Convertible Claims-Made coverage with Prior Acts coverage

### B. Requested Coverage Effective Date:

From (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m. To (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

### C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m. (This date is not required for Occurrence or Claims-Made without Prior Acts policies)

### D. List all previous professional liability insurers in the last ten years:

1. Current Insurer \_\_\_\_\_ Current Premium \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_
2. Previous Insurer: \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_
3. Previous Insurer: \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_

### E. Please explain any gaps in coverage in the past ten years. \_\_\_\_\_

### F. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been purchased.
- An extended reporting endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with The Medical Protective Company, if offered, will not provide prior acts coverage.



Initial Here

**Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**

### G. Limits Desired: \_\_\_\_\_ Per Occurrence/Per Claim Made \_\_\_\_\_ Annual Aggregate

## VI. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

*Please initial the statements below.*

**Mandatory:** All applicants must read and initial the following.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Initial Here

## VII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments"**) for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

**Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC/PA or the Office Administrator or equivalent Authorized Representative.**

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Type or Print Name \_\_\_\_\_ Title \_\_\_\_\_

## VIII. ADDITIONAL INFORMATION

*Attach a separate piece of paper if additional space is needed.*

---

---

---

---

---

---

---

---

---

---

The Medical Protective Company

**DENTAL LOSS INFORMATION SUPPLEMENT**

Please make copies if additional forms are needed.

Applicant's Name \_\_\_\_\_

Note: Additional documentation may be requested at the Company's discretion.

A. Is the matter related to [ ] A, [ ] B or [ ] C (if applicable) from the Loss Information Section? (Check only one)

B. Patient/Claimant Information:

\_\_\_\_\_  
Last Name First Name Age

C. Date of treatment and/or surgery, which led, or could lead, to allegations against you: (MM/YYYY) \_\_\_\_\_

D. Date notice received (if applicable): (MM/YYYY) \_\_\_\_\_

E. Has this matter been reported to your current or former insurer?  Yes  No

If yes, date reported to your current or former insurer? (MM/YYYY) \_\_\_\_\_

Current or former insurer name \_\_\_\_\_

If no, please explain \_\_\_\_\_

F. Name of all other doctor(s), hospital(s) or health care provider(s), if any, involved:

\_\_\_\_\_  
\_\_\_\_\_

G. Current status:  Open  Closed

If open, indicate dollar value established by insurer: \$ \_\_\_\_\_

If closed,

1. Date of closing (MM/YYYY): \_\_\_\_\_

2. Was a payment made?  Yes  No

a. If yes, did you consent to the settlement?  Yes  No

b. Total amount of settlement or award: \$ \_\_\_\_\_

c. Total amount of settlement or award paid on your behalf: \$ \_\_\_\_\_

H. Nature of allegations or potential allegations:

Condition Treated \_\_\_\_\_

Treatment Provided \_\_\_\_\_

Alleged Negligence \_\_\_\_\_

Alleged Injury \_\_\_\_\_

Please provide a narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DENTAL NON-INSURED SUPPLEMENT**



**I. GENERAL INFORMATION**

*Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".*

A. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number (Optional) \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_

B. Current Insurer \_\_\_\_\_ Current Limits \_\_\_\_\_

**II. EDUCATIONAL BACKGROUND**

A. Dental School:  
Name of School \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Degree \_\_\_\_\_ Completed From (MM/DD/YYYY) \_\_\_\_\_ To (MM/DD/YYYY) \_\_\_\_\_

B. Residency:  
(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, etc.)  
(If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty Type \_\_\_\_\_  
Completed?  Yes  No  Still in Training From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

2. Name of Hospital/Facility/Program \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty Type \_\_\_\_\_  
Completed?  Yes  No  Still in Training From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

**III. PRACTICE INFORMATION**

A. States in which you hold a license to practice dentistry:  
Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

	Active	Inactive	Temporary	Pending
1. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No				

## IV. RATING INFORMATION

**A. Please check your present specialty:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Dentist   | <input type="checkbox"/> Prosthodontist                         | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist      | <input type="checkbox"/> Oral Pathologist                       | <input type="checkbox"/> Dual Degree                  |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist                | <input type="checkbox"/> Board Certified              |
| <input type="checkbox"/> Endodontist       | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____                 |
| <input type="checkbox"/> Periodontist      | <input type="checkbox"/> Other (Please explain) _____           |   |

**B. Please check procedures you will perform in your practice.**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Orthodontic Full Mouth Banding</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Placement of Mini Implants for Orthodontic/Prosthesis</b><br><input type="checkbox"/> <b>Implant Prosthesis/Supported Prosthesis</b><br><input type="checkbox"/> <b>Sargenti Root Canal Method Utilizing N2 or Similar Paste</b><br><input type="checkbox"/> <b>Surgical Placement of Implant Fixtures</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Botox, Dermal Fillers (i.e. Injections)</b><br><input type="checkbox"/> <b>Cosmetic Full Mouth Rehabilitation</b><br><input type="checkbox"/> <b>Alternative (Holistic) Dentistry/Medicine</b><br>Please explain _____<br><input type="checkbox"/> <b>Sleep Apnea Therapy</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> <b>Obesity/Weight Control Treatment</b><br><br><b>Third Molar Extractions (CPT/CDT Codes)</b><br><input type="checkbox"/> <b>Erupted (D7110, D7120, D7210)</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Partially Impacted (D7220, D7230)</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Fully Impacted (D7240, D7241, D7250)</b><br>Year you began this procedure (YYYY) _____ | <input type="checkbox"/> <b>Sinus Lifts</b><br><input type="checkbox"/> <b>Palatal Inserts</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> <b>Nerve Grafts</b><br><input type="checkbox"/> <b>Cleft Lip and Palate Surgery</b><br><input type="checkbox"/> <b>Face Lifts</b><br><input type="checkbox"/> <b>Management of Malignant Lesions</b><br><input type="checkbox"/> <b>Orthognathic Surgery</b><br><input type="checkbox"/> <b>Rhinoplasty</b><br><input type="checkbox"/> <b>Skin Peels</b><br><input type="checkbox"/> <b>Spa Services</b><br>Please explain _____<br><input type="checkbox"/> <b>TMJ Services</b><br><input type="checkbox"/> <b>Arthroscopy</b><br><input type="checkbox"/> <b>Implant</b><br><input type="checkbox"/> <b>Reconstruction</b><br><input type="checkbox"/> <b>Trigger Point Injections</b><br><input type="checkbox"/> <b>Other</b><br>Please explain _____ |
|---|---|

**C. Indicate the percentage of your practice devoted to the following procedures:**  
(Total does not have to equal 100%)

- \_\_\_\_\_ % Denture Procedures     Same Day or Economy     Replacement     Relines
- \_\_\_\_\_ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)
- \_\_\_\_\_ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)
- \_\_\_\_\_ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)
- \_\_\_\_\_ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

**D. Please indicate which procedures you perform and whether you obtain informed consent and training for each of the procedures selected.**

- |   | <u>Informed Consent Type</u>   | <u>Training</u>  |
|---|--|--|
| <input type="checkbox"/> Orthodontic Full Mouth Banding             | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Surgical Placement of Implant Fixtures     | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Partially Impacted Third Molar Extractions | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Fully Impacted Third Molar Extractions     | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Nitrous Oxide Analgesia                    | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Conscious Sedation                         | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> General Anesthesia/Unconscious Sedation    | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Facial Surgery                             | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)    | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Other (Please explain) _____               | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None | <input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None |

**E. Have you discontinued any procedures listed in B. or C. above?**  Yes  No

Which procedures? \_\_\_\_\_ When? (MM/DD/YYYY) \_\_\_\_\_

## V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

- Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242* - (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

IM/IV       Oral

- General Anesthesia Utilizing CPT/CDT Code D09220*- (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia were checked, please continue to the back of the application and complete the Anesthesia Supplement.

B.  Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.

## VI. ADDITIONAL PROFESSIONAL INFORMATION

A. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?  Yes  No

If yes, please explain and indicate the date(s):

Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

B. Has any professional liability insurance company ever declined, refused, cancelled, or non-renewed your coverage, or have you ever had an involuntary deductible or surcharge assessed against your policy?  Yes  No

If yes, please explain and indicate the date(s):

Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

C. Have you ever been accused of sexual misconduct of any kind?  Yes  No

If yes, please explain and indicate the date(s):

Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

## VII. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been involved in a claim or suit arising out of the rendering or failure to render professional services?  Yes  No

If yes, how many? \_\_\_\_\_

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes but is not limited to the following:  Yes  No

-Cancer                      -Death                      -Permanent Neurological Injury                      -Permanent Nerve Injury

If yes, how many? \_\_\_\_\_

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?  Yes  No

If yes, how many? \_\_\_\_\_

The Medical Protective Company

**DENTAL ANESTHESIA SUPPLEMENT**

Applicant's Name \_\_\_\_\_

A. If you perform conscious sedation and/or general anesthesia, do you administer sedation for medical procedures?  Yes  No

B. Please indicate who administers Conscious Sedation:

- |   |  |
|---|--|
| <input type="checkbox"/> I Do                         | <input type="checkbox"/> RN/LPN                  |
| <input type="checkbox"/> Oral Surgeon                 | <input type="checkbox"/> Dental Anesthesiologist |
| <input type="checkbox"/> Nurse Anesthetist/CRNA       | <input type="checkbox"/> MD/DO Anesthesiologist  |
| <input type="checkbox"/> Other (Please explain) _____ |  |

Where is Conscious Sedation performed?

- |   |
|---|
| <input type="checkbox"/> In My Office                                     |
| <input type="checkbox"/> Hospital   |
| <input type="checkbox"/> Licensed JCAHO or AAAHC Approved Surgical Center |
| <input type="checkbox"/> Other (Please explain) _____                     |

C. Please indicate who administers General Anesthesia:

- |   |  |
|---|--|
| <input type="checkbox"/> I Do                         | <input type="checkbox"/> RN/LPN                  |
| <input type="checkbox"/> Oral Surgeon                 | <input type="checkbox"/> Dental Anesthesiologist |
| <input type="checkbox"/> Nurse Anesthetist/CRNA       | <input type="checkbox"/> MD/DO Anesthesiologist  |
| <input type="checkbox"/> Other (Please explain) _____ |  |

Where is General Anesthesia performed?

- |   |
|---|
| <input type="checkbox"/> In My Office                                     |
| <input type="checkbox"/> Hospital   |
| <input type="checkbox"/> Licensed JCAHO or AAAHC Approved Surgical Center |
| <input type="checkbox"/> Other (Please explain) _____                     |

D. Do you accept referrals for the administration of anesthesia?  Yes  No

E. Do you prescribe Benzodiazepine type oral sedation agents? (Halcion, Triazolam, Ativan, Vallium or similar anesthetic agent)  Yes  No

If yes, do you exceed the maximum recommended dosage ("MRD")?

Yes  No

If yes, are you trained and is your office prepared to administer reversal agents such as flumazenil intravenously?

Yes  No

F. How often do you update health histories?

Every:  3 Months  6 Months  12 Months  Other \_\_\_\_\_

G. Is your office certified for general anesthesia by a state organization?  Yes  No

If yes, date of issuance: (MM/YYYY) \_\_\_\_\_

H. If conscious sedation or general anesthesia is performed outside of a hospital, JCAHO or AAAHC approved facility, how often do you and your staff participate in simulated emergency training?

Every:  3 Months  6 Months  12 Months  Other \_\_\_\_\_

I. Are you or the individual administering the sedation, certified in one or more of the following?  Yes  No

If yes, please mark the applicable boxes:  CPR  ACLS  ATLS  PALS

J. Do you utilize the following equipment? (Please "X" equipment used)  
Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital, JCAHO or AAAHC approved facility.

**Basic Airway Equipment:**

- |  |  |
|--|--|
| <input type="checkbox"/> Oral and Nasopharyngeal Airways           | <input type="checkbox"/> Pulse Oximeter                              |
| <input type="checkbox"/> Full Face Mask Resuscitator               | <input type="checkbox"/> CO2 Monitor                                 |
| <input type="checkbox"/> Endotracheal Tubes (adult/child size)     | <input type="checkbox"/> Internal/External Temperature Monitor       |
| <input type="checkbox"/> Laryngoscope                              | <input type="checkbox"/> Portable Suction                            |
| <input type="checkbox"/> Direct Current Defibrillator              | <input type="checkbox"/> Capnography                                 |
| <input type="checkbox"/> Tracheostomy/Coniotomy Equipment          | <input type="checkbox"/> Auxillary Lighting                          |
| <input type="checkbox"/> Sphygmomanometer/Stethoscope              | <input type="checkbox"/> Emergency Pharmaceutical Kit                |
| <input type="checkbox"/> Electrocardiographic Monitoring Equipment | <input type="checkbox"/> Fail safe mechanisms on anesthesia machines |

K. If you are hosting anesthesia provider(s), outside of a hospital, JCAHO or AAAHC approved facility, have you and will you ensure those anesthesia provider(s) have:

The equipment indicated (checked) above?  Yes  No

Professional liability limits equal to or greater than your policy limits?  Yes  No

**DENTAL LOSS INFORMATION SUPPLEMENT**

Please make copies if additional forms are needed.

Applicant's Name \_\_\_\_\_

Note: Additional documentation may be requested at the Company's discretion.

A. Is the matter related to [ ] A, [ ] B or [ ] C (if applicable) from the Loss Information Section? (Check only one)

B. Patient/Claimant Information:

\_\_\_\_\_  
Last Name First Name Age

C. Date of treatment and/or surgery, which led, or could lead, to allegations against you: (MM/YYYY) \_\_\_\_\_

D. Date notice received (if applicable): (MM/YYYY) \_\_\_\_\_

E. Has this matter been reported to your current or former insurer?  Yes  No

If yes, date reported to your current or former insurer? (MM/YYYY) \_\_\_\_\_

Current or former insurer name \_\_\_\_\_

If no, please explain \_\_\_\_\_

F. Name of all other doctor(s), hospital(s) or health care provider(s), if any, involved:

\_\_\_\_\_  
\_\_\_\_\_

G. Current status:  Open  Closed

If open, indicate dollar value established by insurer: \$ \_\_\_\_\_

If closed,

1. Date of closing (MM/YYYY): \_\_\_\_\_

2. Was a payment made?  Yes  No

a. If yes, did you consent to the settlement?  Yes  No

b. Total amount of settlement or award: \$ \_\_\_\_\_

c. Total amount of settlement or award paid on your behalf: \$ \_\_\_\_\_

H. Nature of allegations or potential allegations:

Condition Treated \_\_\_\_\_

Treatment Provided \_\_\_\_\_

Alleged Negligence \_\_\_\_\_

Alleged Injury \_\_\_\_\_

Please provide a narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# DENTAL POLICY CHANGE REQUEST



## I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Requested Effective Date of Change: (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

B. General Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number (Optional) \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

E-Mail \_\_\_\_\_

Business Fax \_\_\_\_\_ Business Phone \_\_\_\_\_ Residence/Cell Phone \_\_\_\_\_

C. Practice Location(s):

(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence

Location Name \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

2. Additional Location:

% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence

Location Name \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

D. Preferred Billing and Correspondence Address:

Location Number (From Section B. above) \_\_\_\_\_  Other (please enter below)

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## II. PRACTICE INFORMATION

A. States in which you hold a license to practice dentistry:

Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

- |  | Active                   | Inactive                 | Temporary                | Pending                  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |

### III. RATING INFORMATION

**A. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage:** (If none, please enter '0' in the space provided.)

# Patients Per Week \_\_\_\_\_ Hours Per Week \_\_\_\_\_ Unscheduled New Walk-In Patients Per Week \_\_\_\_\_

**B. Please check your present specialty:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Dentist   | <input type="checkbox"/> Prosthodontist                         | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist      | <input type="checkbox"/> Oral Pathologist                       | <input type="checkbox"/> Dual Degree                  |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist                | <input type="checkbox"/> Board Certified              |
| <input type="checkbox"/> Endodontist       | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____                 |
| <input type="checkbox"/> Periodontist      | <input type="checkbox"/> Other (Please explain) _____           |   |

**C. Please check procedures you will perform in your practice:**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Orthodontic Full Mouth Banding</b><br>Year you began this procedure (YYYY) _____  | <input type="checkbox"/> <b>Sinus Lifts</b>   |
| <input type="checkbox"/> <b>Placement of Mini Implants for Orthodontic/Prosthesis</b>   | <input type="checkbox"/> <b>Palatal Inserts</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> <b>Implant Prosthesis/Supported Prosthesis</b>   | <input type="checkbox"/> <b>Nerve Grafts</b>  |
| <input type="checkbox"/> <b>Sargent's Root Canal Method Utilizing N2 or Similar Paste</b>   | <input type="checkbox"/> <b>Cleft Lip and Palate Surgery</b>  |
| <input type="checkbox"/> <b>Surgical Placement of Implant Fixtures</b><br>Year you began this procedure (YYYY) _____  | <input type="checkbox"/> <b>Face Lifts</b>  |
| <input type="checkbox"/> <b>Botox, Dermal Fillers (i.e. Injections)</b>   | <input type="checkbox"/> <b>Management of Malignant Lesions</b>   |
| <input type="checkbox"/> <b>Cosmetic Full Mouth Rehabilitation</b>  | <input type="checkbox"/> <b>Orthognathic Surgery</b>  |
| <input type="checkbox"/> <b>Alternative (Holistic) Dentistry/Medicine</b><br>Please explain _____   | <input type="checkbox"/> <b>Rhinoplasty</b>   |
| <input type="checkbox"/> <b>Sleep Apnea Therapy</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> <b>Skin Peels</b>  |
| <input type="checkbox"/> <b>Obesity/Weight Control Treatment</b>  | <input type="checkbox"/> <b>Spa Services</b><br>Please explain _____  |
| <b>Third Molar Extractions (CPT/CDT Codes)</b>  | <input type="checkbox"/> <b>TMJ Services</b>  |
| <input type="checkbox"/> <b>Erupted (D7110, D7120, D7210)</b><br>Year you began this procedure (YYYY) _____   | <input type="checkbox"/> <b>Arthroscopy</b>   |
| <input type="checkbox"/> <b>Partially Impacted (D7220, D7230)</b><br>Year you began this procedure (YYYY) _____   | <input type="checkbox"/> <b>Implant</b>   |
| <input type="checkbox"/> <b>Fully Impacted (D7240, D7241, D7250)</b><br>Year you began this procedure (YYYY) _____  | <input type="checkbox"/> <b>Reconstruction</b>  |
|   | <input type="checkbox"/> <b>Trigger Point Injections</b>  |
|   | <input type="checkbox"/> <b>Other</b><br>Please explain _____   |

**D. Indicate the percentage of your practice devoted to the following procedures:**  
(Total does not have to equal 100%)

- \_\_\_\_\_ % Denture Procedures     Same Day or Economy     Replacement     Relines
- \_\_\_\_\_ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)
- \_\_\_\_\_ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)
- \_\_\_\_\_ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)
- \_\_\_\_\_ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

### III. RATING INFORMATION (CONTINUED)

**E. Please indicate which procedures you perform and whether you obtain informed consent and training for each of the procedures selected.**

	<b>Informed Consent Type</b>	<b>Training</b>
<input type="checkbox"/> Orthodontic Full Mouth Banding	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Surgical Placement of Implant Fixtures	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Partially Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Fully Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Nitrous Oxide Analgesia	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> General Anesthesia/Unconscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Facial Surgery	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Other (Please explain): _____	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None

**F. Have you discontinued any procedures listed in C. or D. above?**  Yes  No

Which procedures? \_\_\_\_\_ When? (MM/DD/YYYY) \_\_\_\_\_

**G. Do you treat non-federal prison inmates?**  Yes  No

If yes, what percentage of your practice is devoted to treating non-federal inmates? \_\_\_\_\_ %

**H. Do you treat or review treatment of federal prison inmates?**  Yes  No

If yes, please explain \_\_\_\_\_

### IV. PRACTICE ORGANIZATION INFORMATION

Please check boxes that best describe your practice affiliation(s).

**A. Employment Status:**

Employee  Shareholder/Partner  Independent Contractor  Other Date Joined/formed (MM/DD/YYYY) \_\_\_\_\_

**B. Entity / Organization Type:** (You must check at least one box.)

- |  |  |
|--|--|
| <input type="checkbox"/> Solo Unincorporated/Sole Proprietor<br><input type="checkbox"/> Solo Incorporated<br><input type="checkbox"/> Multi-Shareholder Corporation, Partnership, Limited Liability Company<br><input type="checkbox"/> State Licensed Dental Surgery Center<br><input type="checkbox"/> Clinic Receives Governmental Immunity<br><input type="checkbox"/> Other (Please explain) _____ | <input type="checkbox"/> Mobile or Portable Dental Practice<br><input type="checkbox"/> Nursing Home Based Practice<br><input type="checkbox"/> Dental School - Faculty<br><input type="checkbox"/> Clinical supervision of students<br>Hours per week _____<br><input type="checkbox"/> Dental Students/Residents |
|--|--|

**C. Name all of your affiliated professional corporations or associations (including DBA's and Individual Dentists):**

\_\_\_\_\_

**D. Is this entity or employer currently insured with The Medical Protective Company?**

If yes, please provide The Medical Protective Company individual, corporation or partnership policy and group number, if known.

Policy # \_\_\_\_\_ Group # \_\_\_\_\_  Yes  No

**E. Do you desire coverage for this entity?**  Yes  No

If yes, please select the type of entity coverage desired:

- Shared Limit** - Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.
- Separate Limit** - Available for all Entity/Organization Types. A separate entity application is required.

*To request separate entity coverage, please contact your agent or Med Pro customer service (800-4MedPro) to complete an entity application for consideration.*

## V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

- Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242* - (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

IM/IV       Oral

- General Anesthesia Utilizing CPT/CDT Code D09220* - (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

*If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.*

B.  Please "X" here if this section *does not* apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.

## VI. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes     No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please Note:** Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

## VII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments"**) for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Type or Print Name \_\_\_\_\_



# DENTAL NEW GRADUATE APPLICATION



## I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number (Optional) \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Business Fax \_\_\_\_\_ Business Phone \_\_\_\_\_ Residence/Cell Phone \_\_\_\_\_

B. Practice Location(s):  
(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:  
% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence  
Location Name \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

2. Additional Location:  
% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence  
Location Name \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

C. Preferred Billing and Correspondence Address:  
 Location Number (From Section B. above) \_\_\_\_\_  Other (please enter below)  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND

A. Have you completed a risk management education course within the last twelve (12) months?  Yes  No  
If you have answered yes, did the course provide all of the following:  Yes  No

- 1. A minimum of three continuing dental education (CDE) hours;
- 2. Sponsored by an approved national/regional dental education sponsor; and
- 3. Strictly adhere to a risk management (loss prevention) curriculum

B. Dental School:  
1. Name of School \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Degree \_\_\_\_\_ Completed From (MM/YYYY) \_\_\_\_\_ to (MM/YYYY) \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND (CONTINUED)

**C. Residency:**

(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, etc.)  
(If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty Type \_\_\_\_\_  
 Completed?  Yes  No  Still in Training From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_
  
2. Name of Hospital/Facility/Program \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty Type \_\_\_\_\_  
 Completed?  Yes  No  Still in Training From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

## III. RATING INFORMATION

**A. Please check your present specialty:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Dentist   | <input type="checkbox"/> Prosthodontist                         | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist      | <input type="checkbox"/> Oral Pathologist                       | <input type="checkbox"/> Dual Degree                  |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist                | <input type="checkbox"/> Board Certified              |
| <input type="checkbox"/> Endodontist       | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____                 |
| <input type="checkbox"/> Periodontist      | <input type="checkbox"/> Other (Please explain) _____           |   |

**B. Please check procedures you will perform in your practice:**

**Third Molar Extractions (CPT/CDT Codes)**

- |   |   |
|---|---|
| <input type="checkbox"/> Erupted (D7110, D7120, D7210)<br>Year you began this procedure (YYYY) _____        | <input type="checkbox"/> Surgical Placement of Implant Fixtures<br>Year you began this procedure (YYYY) _____ |
| <input type="checkbox"/> Partially Impacted (D7220, D7230)<br>Year you began this procedure (YYYY) _____    | <input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)  |
| <input type="checkbox"/> Fully Impacted (D7240, D7241, D7250)<br>Year you began this procedure (YYYY) _____ | <input type="checkbox"/> Other<br>Please explain _____  |

**C. States in which you hold a license to practice dentistry:**

Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

- |  | Active                   | Inactive                 | Temporary                | Pending                  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |

**D. Please indicate estimated average weekly hours of practice per week for which you require coverage:** \_\_\_\_\_

## IV. ADDITIONAL PROFESSIONAL INFORMATION

- A. Do you treat or review treatment of federal prison inmates?**  Yes  No  
 If yes, please explain \_\_\_\_\_
- B. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?**  Yes  No  
 If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

#### IV. ADDITIONAL PROFESSIONAL INFORMATION (CONTINUED)

C. Have you ever been accused of sexual misconduct of any kind?  Yes  No  
If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

D. Have you ever incurred or become aware of having a condition that impairs your ability to practice your dental specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.)  Yes  No

If yes, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type(s) of Illness \_\_\_\_\_  
Date(s) of Treatment(s): From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_  
Treating Physician(s): Name(s) \_\_\_\_\_ Address(es) \_\_\_\_\_

E. Are you affiliated with a group that has more than three active locations?  Yes  No

F. Are you affiliated with a management service organization or dental practice franchise?  Yes  No

#### V. PRACTICE ORGANIZATION INFORMATION

A. Name of all your partnership's professional corporations or associations (including DBA's and Individual Dentists).  
\_\_\_\_\_

B. Is this entity or employer currently insured with The Medical Protective Company?  Yes  No

If yes, please provide The Medical Protective Company individual, corporation or partnership policy number and group number, if known.

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

C. Do you desire coverage for this entity?  Yes  No

If yes, please select the type of entity coverage desired:

**Shared Limit** - Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.

**Separate Limit** - Available for all Entity/Organization Types. A separate entity application is required.

*To request separate entity coverage, please contact your agent or Med Pro customer service (800-4MedPro) to complete an entity application for consideration.*

#### VI. LOSS INFORMATION

Please complete the Loss Information Supplement for each incident, claim or suit.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints etc...)

For question B below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim or suit arising out of the rendering or failure to render professional services?  Yes  No

If yes, how many? \_\_\_\_\_

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes but is not limited to the following:  Yes  No

-Cancer                      -Death                      -Permanent Neurological Injury                      -Permanent Nerve Injury

If yes, how many? \_\_\_\_\_

## VII. COVERAGE INFORMATION

### A. Coverage Desired:

- Occurrence  
 STEP into Occurrence (Student Transitional Entry Program)  
 Claims-Made coverage without Prior Acts coverage  
 Claims-Made coverage with Prior Acts coverage

### B. Requested Coverage Effective Date:

From (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m. To (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

### C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m. (This date is not required for Occurrence or Claims-Made without Prior Acts policies)

### D. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been purchased.  
 An extended reporting endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with The Medical Protective Company, if offered, will not provide prior acts coverage.

Initial Here

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".

E. Limits Desired: \_\_\_\_\_ Per Occurrence/Per Claim Made \_\_\_\_\_ Annual Aggregate

## VIII. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes  No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.



# DENTAL INDIVIDUAL APPLICATION



## I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number (Optional) \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Business Fax \_\_\_\_\_ Business Phone \_\_\_\_\_ Residence/Cell Phone \_\_\_\_\_

B. Practice Location(s):  
(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence  
Location Name \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

2. Additional Location:

% of Practice \_\_\_\_\_ Type of Location:  Hospital  Office  Residence  
Location Name \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

C. Preferred Billing and Correspondence Address:

Location Number (From Section B. above) \_\_\_\_\_  Other (please enter below) \_\_\_\_\_  
Number and Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND

A. Are you entering private practice for the first time?  Yes  No

B. Have you completed a risk management education course within the last twelve (12) months?  Yes  No

If you answered yes, did the course provide all of the following?  Yes  No

- 1. A minimum of three continuing dental education (CDE) hours;
- 2. Sponsored by an approved national/regional dental education sponsor; and
- 3. Strictly adheres to a risk management (loss prevention) curriculum

C. Dental School:

Name of School \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Degree \_\_\_\_\_ Completed From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND (CONTINUED)

**D. Residency:**

(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, etc.)  
(If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty Type \_\_\_\_\_  
 Completed?  Yes  No  Still In Training      From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_
  
2. Name of Hospital/Facility/Program \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty Type \_\_\_\_\_  
 Completed?  Yes  No  Still In Training      From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

## III. PRACTICE INFORMATION

**A. States in which you hold a license to practice dentistry:**

Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

- |  | Active                   | Inactive                 | Temporary                | Pending                  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State _____ License # _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                          |                          |                          |

**B. Please indicate your earliest start date at your current location(s):** (MM/YYYY) \_\_\_\_\_

**C. Do you have previous practice locations?**  Yes  No

If yes, list most recent location first dating back within the past ten years.

1. Name of Practice \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty \_\_\_\_\_ From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_
  
2. Name of Practice \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
 Specialty \_\_\_\_\_ From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_

**D. In the past ten years, please explain any gaps greater than one year between practice locations.** \_\_\_\_\_  
 \_\_\_\_\_

**E. To which dental societies or associations do you belong?** \_\_\_\_\_  
 \_\_\_\_\_

**F. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage:** (if none, please enter '0' in the space provided.)

# Patients Per Week \_\_\_\_\_ Hours Per Week \_\_\_\_\_ Unscheduled New Walk-In Patients Per Week \_\_\_\_\_

## IV. RATING INFORMATION

**A. Please check your present specialty:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Dentist   | <input type="checkbox"/> Prosthodontist                         | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist      | <input type="checkbox"/> Oral Pathologist                       | <input type="checkbox"/> Dual Degree                  |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist                | <input type="checkbox"/> Board Certified              |
| <input type="checkbox"/> Endodontist       | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____                 |
| <input type="checkbox"/> Periodontist      | <input type="checkbox"/> Other (Please explain) _____           |   |

**B. Please check procedures you will perform in your practice:**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Orthodontic Full Mouth Banding</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Placement of Mini Implants for Orthodontic/Prosthesis</b><br><input type="checkbox"/> <b>Implant Prosthesis/Supported Prosthesis</b><br><input type="checkbox"/> <b>Sargenti Root Canal Method Utilizing N2 or Similar Paste</b><br><input type="checkbox"/> <b>Surgical Placement of Implant Fixtures</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Botox, Dermal Fillers (i.e. Injections)</b><br><input type="checkbox"/> <b>Cosmetic Full Mouth Rehabilitation</b><br><input type="checkbox"/> <b>Alternative (Holistic) Dentistry/Medicine</b><br>Please explain _____<br><input type="checkbox"/> <b>Sleep Apnea Therapy</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> <b>Obesity/Weight Control Treatment</b><br><br><u>Third Molar Extractions (CPT/CDT Codes)</u><br><input type="checkbox"/> <b>Erupted (D7110, D7120, D7210)</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Partially Impacted (D7220, D7230)</b><br>Year you began this procedure (YYYY) _____<br><input type="checkbox"/> <b>Fully Impacted (D7240, D7241, D7250)</b><br>Year you began this procedure (YYYY) _____ | <input type="checkbox"/> <b>Sinus Lifts</b><br><input type="checkbox"/> <b>Palatal Inserts</b><br>Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> <b>Nerve Grafts</b><br><input type="checkbox"/> <b>Cleft Lip and Palate Surgery</b><br><input type="checkbox"/> <b>Face Lifts</b><br><input type="checkbox"/> <b>Management of Malignant Lesions</b><br><input type="checkbox"/> <b>Orthognathic Surgery</b><br><input type="checkbox"/> <b>Rhinoplasty</b><br><input type="checkbox"/> <b>Skin Peels</b><br><input type="checkbox"/> <b>Spa Services</b><br>Please explain _____<br><input type="checkbox"/> <b>TMJ Services</b><br><input type="checkbox"/> <b>Arthroscopy</b><br><input type="checkbox"/> <b>Implant</b><br><input type="checkbox"/> <b>Reconstruction</b><br><input type="checkbox"/> <b>Trigger Point Injections</b><br><input type="checkbox"/> <b>Other</b><br>Please explain _____ |
|---|---|

**C. Indicate the percentage of your practice devoted to the following procedures:**  
(Total does not have to equal 100%)

- \_\_\_\_\_ % Denture Procedures       Same Day or Economy       Replacement       Relines
- \_\_\_\_\_ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)
- \_\_\_\_\_ % Elective Facial Cosmetic Surgical Procedures (Including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)
- \_\_\_\_\_ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)
- \_\_\_\_\_ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

**D. Please indicate which procedures you perform and whether you obtain informed consent and have received training for each of the procedures selected.**

	<u>Informed Consent Type</u>	<u>Training</u>
<input type="checkbox"/> Orthodontic Full Mouth Banding	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Surgical Placement of Implant Fixtures	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Partially Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Fully Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Nitrous Oxide Analgesia	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> General Anesthesia/Unconscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Facial Surgery	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Other (Please explain) _____	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None

**E. Have you discontinued any procedures listed in B. or C. above?**  Yes  No

Which procedures? \_\_\_\_\_ When? (MM/DD/YYYY) \_\_\_\_\_

## V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

*Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242 - (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.*

IM/IV       Oral

*General Anesthesia Utilizing CPT/CDT Code D09220- (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.*

*If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.*

B.  Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.

## VI. ADDITIONAL PROFESSIONAL INFORMATION

A. Do you treat non-federal prison inmates?  Yes  No  
If yes, what percentage of your practice is devoted to treating non-federal inmates? \_\_\_\_\_ %

B. Do you treat or review treatment of federal prison inmates?  Yes  No  
If yes, please explain \_\_\_\_\_  
(If you are covered by other insurance for the activities in A or B of this section, please complete Section VI, Question J.)

C. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?  Yes  No  
If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

D. Has any professional liability insurance company ever declined, refused, cancelled, or non-renewed your coverage, or have you ever had an involuntary deductible or surcharge assessed against your policy?  Yes  No  
If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

E. Have you ever been accused of sexual misconduct of any kind?  Yes  No  
If yes, please explain and indicate the date(s): Please explain \_\_\_\_\_ (MM/YYYY) \_\_\_\_\_

F. Have you ever incurred or become aware of having a condition that impairs your ability to practice your dental specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.)  Yes  No

If yes, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type(s) of Illness \_\_\_\_\_  
Date(s) of Treatment(s): From (MM/YYYY) \_\_\_\_\_ To (MM/YYYY) \_\_\_\_\_  
Treating Physician(s): Name(s) \_\_\_\_\_ Address(es) \_\_\_\_\_

G. Do you use a collection agency which has the authority to file collection suits without your knowledge?  Yes  No

H. Is the standard of care altered based on the patient's, custodial parent's or legal guardian's ability to pay?  Yes  No

I. Are you affiliated with a group that has more than three active locations?  Yes  No

J. Will you be performing activities which will be covered by another professional liability policy?  Yes  No

If yes, are you an:  Employee     Independent Contractor     Resident/Fellow     Faculty

Practice Name \_\_\_\_\_

Location \_\_\_\_\_

Name of Insurer \_\_\_\_\_

K. Are you affiliated with a management service organization or dental practice franchise?  Yes  No

## VII. PRACTICE ORGANIZATION INFORMATION

Please check boxes that best describe your practice affiliation(s).

### A. Employment Status:

Employee  Shareholder/Partner  Independent Contractor  Other Date Joined/Formed (MM/DD/YYYY) \_\_\_\_\_

### B. Entity / Organization Type: (You must check at least one box.)

- Solo Unincorporated/Sole Proprietor  
 Solo Incorporated  
 Multi-Shareholder Corporation, Partnership, Limited Liability Company  
 Licensed Dental Surgery Center  
 Clinic Receives Governmental Immunity  
 Other (Please explain) \_\_\_\_\_
- Mobile Dental Practice  
 Nursing Home Based Practice  
 Dental School - Faculty  
 Clinical supervision of students  
Hours per week \_\_\_\_\_  
 Dental Students/Residents

### C. Name all of your affiliated professional corporations or associations (Including DBA's and Individual Dentists):

\_\_\_\_\_

D. Is this entity or employer currently insured with The Medical Protective Company?  Yes  No

If yes, please provide The Medical Protective Company Individual, corporation or partnership policy and group number, if known.

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

E. Do you desire coverage for this entity?  Yes  No

If yes, please select the type of entity coverage desired:

- Shared Limit** - Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.
- Separate Limit** - Available for all Entity/Organization Types. A separate entity application is required.

*To request separate entity coverage, please contact your agent or Med Pro customer service (800-4MedPro) to complete an entity application for consideration.*

## VIII. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been involved in a claim or suit arising out of the rendering or failure to render professional services?  Yes  No

If yes, how many? \_\_\_\_\_

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes but is not limited to the following:  Yes  No

-Cancer                      -Death                      -Permanent Neurological Injury                      -Permanent Nerve Injury

If yes, how many? \_\_\_\_\_

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?  Yes  No

If yes, how many? \_\_\_\_\_

## IX. COVERAGE INFORMATION

### A. Coverage Desired:

- Occurrence  
 Claims-Made coverage without Prior Acts coverage  
 Claims-Made coverage with Prior Acts coverage  
 Convertible Claims-Made coverage with Prior Acts coverage

### B. Requested Coverage Effective Date:

From (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m. To (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

### C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) \_\_\_\_\_ 12:01 a.m.

(This date is not required for Occurrence or Claims-Made without Prior Acts policies)

### D. List all previous professional liability insurers in the last ten years:

1. Current Insurer \_\_\_\_\_ Current Premium \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_
2. Previous Insurer: \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_
3. Previous Insurer: \_\_\_\_\_  
 Occurrence  Claims-Made From (MM/DD/YYYY) \_\_\_\_\_ to (MM/DD/YYYY) \_\_\_\_\_

### E. Please explain any gaps in coverage in the past ten years. \_\_\_\_\_

### F. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been purchased.  
 An extended reporting endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with The Medical Protective Company, if offered, will not provide prior acts coverage.

Initial Here

**Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**

### G. Limits Desired: \_\_\_\_\_ Per Occurrence/Per Claim Made \_\_\_\_\_ Annual Aggregate

## X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes  No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name \_\_\_\_\_

Number and Street \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.**

## XI. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

*Please initial the statements below.*

**Mandatory:** All applicants must read and initial the following:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Initial Here

## XII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments"**) for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Type or Print Name \_\_\_\_\_

## XIII. ADDITIONAL INFORMATION

*Attach a separate piece of paper if additional space is needed.*

---

---

---

---

---

---

---

---

---

---



SERFF Tracking Number: MDPC-125887413

State: Arkansas

Filing Company: The Medical Protective Company

State Tracking Number: EFT \$50

Company Tracking Number: 08-DA-01

TOI: 11.0 Medical Malpractice - Claims  
Made/Occurrence

Sub-TOI: 11.0000 Med Mal Sub-TOI Combinations

Product Name: Dentists

Project Name/Number: Dentists Application Filing/08-DA-01

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Uniform Transmittal Document- Property & Casualty	<b>Review Status:</b>	Approved	01/09/2009
<b>Comments:</b>	attached			
<b>Attachment:</b>	20081105123409001.pdf			

<b>Satisfied -Name:</b>	listing of applications (memo)	<b>Review Status:</b>	Approved	01/09/2009
<b>Comments:</b>	attached			
<b>Attachment:</b>	dds app memo.pdf			

Property & Casualty Transmittal Document

Reset Form

**1. Reserved for Insurance Dept. Use Only**

**2. Insurance Department Use only**

a. Date the filing is received:

b. Analyst:

c. Disposition:

d. Date of disposition of the filing:

e. Effective date of filing:

New Business	
Renewal Business	

f. State Filing #:

g. SERFF Filing #:

h. Subject Codes

<b>3.</b>	<b>Group Name</b>					<b>Group NAIC #</b>
<b>4.</b>	<b>Company Name(s)</b>	<b>Domicile</b>	<b>NAIC #</b>	<b>FEIN #</b>	<b>State #</b>	
	The Medical Protective Co	IN	11843	35-0506406		

**5. Company Tracking Number** 08-DA-01

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

<b>6.</b>	<b>Name and address</b>	<b>Title</b>	<b>Telephone #s</b>	<b>FAX #</b>	<b>e-mail</b>
	Melissa Coker	Paralegal	260-486-0838	260-486-0733	melissa.coker@medpro.com
	5814 Reed Road, Fort Wayne, IN 46835				
<b>7.</b>	Signature of authorized filer		<i>Melissa Coker</i>		
<b>8.</b>	Please print name of authorized filer		Melissa Coker, Paralegal		

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

<b>9.</b>	<b>Type of Insurance (TOI)</b>	11.0 Med Mal-Claims Made and Occurrence			
<b>10.</b>	<b>Sub-Type of Insurance (Sub-TOI)</b>	11.0030 Dentist			
<b>11.</b>	<b>State Specific Product code(s)(if applicable)[See State Specific Requirements]</b>				
<b>12.</b>	<b>Company Program Title (Marketing title)</b>	Dentists Program			
<b>13.</b>	<b>Filing Type</b>	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)			
<b>14.</b>	<b>Effective Date(s) Requested</b>	New:	04/01/2009	Renewal:	04/01/2009
<b>15.</b>	<b>Reference Filing?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
<b>16.</b>	<b>Reference Organization (if applicable)</b>	n/a -			
<b>17.</b>	<b>Reference Organization # &amp; Title</b>	n/a -			
<b>18.</b>	<b>Company's Date of Filing</b>	11/05/08			
<b>19.</b>	<b>Status of filing in domicile</b>	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved			

## Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking # 08-DA-01

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

FORM FILING:

The reason for the filing is to introduce several new applications used by the Dentists program to underwrite busineses. We ask this filing be effective as of April 1, 2009.

[View Complete Filing Description](#)

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.)

PC TD-1 pg 2 of 2

## 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.)

<b>1.</b>	<b>This filing transmittal is part of Company Tracking #</b>	08-DA-01			
<b>2.</b>	<b>This filing corresponds to rate/rule filing number</b> <small>(Company tracking number of rate/rule filing, if applicable)</small>	n/a - application only filing			
<b>3.</b>	<b>Form Name /Description/Synopsis</b>	<b>Form # Include edition date</b>	<b>Replacement Or withdrawn?</b>	<b>If replacement, give form # it replaces</b>	<b>Previous state filing number, if required by state</b>
01	Dental Anesthesia Supplement	Dental Anesthesia-Supp-00; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02	Application-Student Dental Board Coverage	DBA-0100-00 ; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03	Dental Entity Application	Dental-Entity-AR ; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04	Dental Loss Information Supplement	Dental Loss Information - Supp-00; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05	Dental Non-Insured Supplement	Non-Insured-Supp-00 ; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06	Dental Policy Change Request	Dental-Change-00 ; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07	Dental New Graduate Application	Dental-Grad-AR ; 06/08 edt	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08	Dental Individual Application	Dental-Indv-AR ; 06/08 edt	<input checked="" 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

# The Medical Protective Company

## Dentists Program Revised Application Form Filing

Form Number	Form Name	Description
Dental-Indv-00 (06/01/2008)	Dental Individual Application	Application for New Business Dentists and becomes part of the insureds policy.
Dental-Grad-00 (06/01/2008)	Dental New Graduate Application	Application for New Graduate Dentists and becomes part of the insureds policy.
Dental-Entity-00 (06/01/2008)	Dental Entity Application	Application for Dental Partnership, Corporations, or Associations and becomes part of the insureds policy.
Dental-Change-00 (06/01/2008)	Dental Policy Change Request	Required when rating/exposure changes occur within the insureds practice (ie: Location, procedures performed, etc). This application becomes part of the policy
Non-Insured-Supp-00 (06/01/2008)	Dental Non-Insured Supplement	Required when Partnership, Corporation or Association contains members which are not insured by MP Co. This application becomes part of the insureds policy.
Dental Anesthesia-Supp-00 (06/01/2008)	Anesthesia Supplement	Additional information needed only for those Dentists which utilize anesthesia. This supplement becomes part of the insureds policy
Dental Loss Information-Supp-00 (06/01/2008)	Loss Information Supplement	This supplement is required when the applicant has additional loss information that needs to be provided to MCPo for risk assessment. This supplement becomes part of the insureds policy.
DBA-0100-00 (02/08)	Student Dental Board Coverage	This application is used for dental students that have not yet taken the Dental Board Exam.