



The Professional Protector Plan®

Claims-Made

Professional Liability Insurance For Dentists



THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant.
3. A copy of your letterhead must be included. Also, please include a copy of all of your "Yellow Pages" advertising, if any.

I agree that any coverage issued will be contingent upon the truth of the following information:

LIMITS REQUESTED:		<input type="checkbox"/> New Policy	Requested Effective Date: ___/___/___
<input type="checkbox"/> \$1,000,000 / \$3,000,000	<input type="checkbox"/> \$3,000,000 / \$6,000,000		
<input type="checkbox"/> \$2,000,000 / \$3,000,000	<input type="checkbox"/> \$4,000,000 / \$4,000,000	<input type="checkbox"/> Rewrite of Policy Number: _____	
<input type="checkbox"/> \$2,000,000 / \$4,000,000	<input type="checkbox"/> \$5,000,000 / \$5,000,000		
<input type="checkbox"/> \$3,000,000 / \$3,000,000	<input type="checkbox"/> \$5,000,000 / \$8,000,000		
<input type="checkbox"/> Other: \$ _____ / \$ _____		Website: _____	
(STATE EXCEPTIONS: IN, FL, KS, PR, NY, SC, VA)			

PLEASE TELL US ABOUT YOURSELF

1. Name: (First/Middle Initial/Last/Designation) <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> MD <input type="checkbox"/> BDS		2. Date of Birth(mm/dd/yyyy) :	
3. Mailing Address: _____ Street City State Zip Code			
4. Telephone Number: () _____	5. Fax Number: () _____	6. E-mail Address: _____	
7. Years in Practice: _____	8. Dental School Attended: _____	9. Month/Year of Graduation (mm/yyyy): _____	
10. Are you entering practice for the first time? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", did you complete a residency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specialty: _____		Month/Year of Completion: _____	
11. Business structure under which you practice (Check all that apply):			
A. <input type="checkbox"/> Employee <input type="checkbox"/> Independent contractor <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Incorporated <input type="checkbox"/> Partnership <input type="checkbox"/> L. L. C. <input type="checkbox"/> L. L. P.			
<input type="checkbox"/> Professional Association <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Other (describe) _____			
Provide the name of the legal entity _____			
Do you desire shared or separate limit of liability to apply to this entity?			
<input type="checkbox"/> Shared (limits are shared with you) <input type="checkbox"/> Separate (entity has its own set of limits)			
B. Besides yourself, list the names of all dentists who are partners/corporate officers for all legal entities: (If additional space is needed, please list on a separate sheet of paper). (Note: All partners/ corporate officers must be insured by CNA)			
_____ Name	_____ Social Security No.	_____ Name	_____ Social Security No.
_____ Name	_____ Social Security No.	_____ Name	_____ Social Security No.
_____ Name	_____ Social Security No.	_____ Name	_____ Social Security No.
C. If you own your practice, please provide the number of the following who work for you:		# of full-time	# of part-time
Employee dentists (other than yourself and/or partners/corporate officers)?.....		_____	_____
(Attach separate application or proof of professional liability insurance)			
Independent Contractor dentists.....		_____	_____
(Attach separate application or proof of professional liability insurance)			
All other employees (i.e., hygienist, dental assistants, technicians, etc.)		_____	_____
Total		0	0

D. Do you work for another dentist as an independent contractor dentist?..... Yes No
 If **“Yes”**, please provide the name of the employer/facility: _____

E. Do you work for another dentist as an employee dentist?..... Yes No
 If **“Yes”**, please provide the name of the employer/facility: _____

F. Do you share dental facilities with other dentists who are not covered under this policy? Yes No
 If **“Yes”**, attach proof of professional liability insurance for the other dentists

12. Practice Addresses and Percentage of Practice at Each Address (**Total of Percentages Must Equal 100%**):

Primary

1) _____
 Street City County State Zip Code %

2) _____
 Street City County State Zip Code %

3) _____
 Street City County State Zip Code %

13. Are you a member of your state dental association or society?..... Yes No

14. How many hours per week do you practice (include lab work, patient visitation and consultation)? _____
If 20 hours or less, please complete a Part-time Supplement

15. Are you currently licensed to practice dentistry?..... Yes No
 State(s): _____ License #(s): _____

16. Have you taken one of the following risk management seminars in the last 3 years?..... Yes No
 CNA (Evidence not required if you are a CNA insured) Hartford AAOMS AAO Princeton NYSDA
 Date of Attendance ____/____/____ If **“Yes”**, provide evidence of attendance.

17. Indicate your practice specialty :

<input type="checkbox"/> General Dentistry	<input type="checkbox"/> Periodontics	<input type="checkbox"/> Anesthesiology(Dental)-General Anesthesia
<input type="checkbox"/> Endodontics	<input type="checkbox"/> Oral Radiology	<input type="checkbox"/> Prosthodontics
<input type="checkbox"/> Oral/Maxillofacial Surgery	<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Public Health
<input type="checkbox"/> Oral Pathology	<input type="checkbox"/> Pediatric Dentistry	<input type="checkbox"/> Full-time Faculty-Non-Intramural
<input type="checkbox"/> Anesthesiology(Dental)-Conscious Sedation		

18. Which of the following procedures are performed by you:

Irreversible TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

Implant Surgery Extraction of Impacted teeth Implant Restoration Molar Endodontics on Permanent Teeth

“Sargenti,” paste fill or formaldehyde based endodontic techniques excluding formocresol primary tooth pulpotomies

Sleep Apnea Therapy If **“Yes”**, please indicate the following:
 I treat only after referral from physician I treat without physician referral I fabricate snore guard

Cosmetic **dermal** procedures (including Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)
 If **“Yes”**, please provide an explanation on a separate sheet of paper.

Consulting Services that are provided as an extension of your primary practice. Such as providing education, training, practice management consulting or expert witness testimony
 Yes, add consulting services (an additional charge applies) No thank you

None of the above

19. A. Have you ever had a change in the status of your hospital privileges?..... Yes No
 If **“Yes”**, provide details on a separate sheet of paper.

B. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? Yes No
 If **“Yes”**, provide a copy of the board transcript or other documentation, including resolution.

C. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? Yes No
 If **“Yes”**, provide a copy of the board transcript or other documentation, including resolution.

D. Have you been convicted of any criminal charges?..... Yes No
 If **“Yes”**, provide details from investigating agency.

E. Have you ever been treated for alcoholism, drug addiction, mental illness or physical impairment? Yes No
 If **“Yes”**, provide a letter from treating physician with complete details.

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

20. A. Is your practice limited to the use of local anesthesia, oral medication and/or nitrous oxide?..... Yes No
Anxiety Reduction is defined as “the use of nitrous oxide/oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety.”
- B. Are you treating patients who are under conscious sedation? Yes No
Conscious sedation is defined as: “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.”
- C. Are you treating patients who are under general anesthesia / deep sedation?..... Yes No
General Anesthesia and Deep Sedation are defined as: “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 purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.”
 If “**Yes**”, where are the procedures performed? In your office In a hospital or surgical center
 If “**In Your Office**”, who administers the anesthesia? You Another Dentist, Anesthesiologist or CRNA

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

21. Are you now, or have you ever, practiced without professional liability insurance?..... Yes No
 If “**Yes**”, provide dates and reason:
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22. Have you ever had any professional liability insurance refused, cancelled or non-renewed?..... Yes No
 If “**Yes**”, provide dates and reason: **(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)**
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23. Has any claim or suit for alleged malpractice ever been brought against you?..... Yes No
 If “**Yes**”, please complete Supplemental Claim form.

24. Are you currently aware of any situation that could lead to a malpractice suit against you?..... Yes No
 If “**Yes**”, please complete Supplemental Claim form.

25. List prior carrier(s) for the past **three (3)** years. If none, state “None.”

Insurer	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability
_____	_____	_____	Occurrence	_____
_____	_____	_____	Occurrence	_____
_____	_____	_____	Occurrence	_____

26. Are you applying for prior acts coverage from CNA?..... Yes No
 If “**Yes**”, please attach a copy of your last declaration page (face sheet).

27. Prior Acts date (Retroactive date) used by your previous carrier_____

28. Was an extended reporting endorsement (tail) purchased from your previous carrier?..... Yes No

PLEASE TELL US ABOUT YOUR PREMISES/OPERATIONS

30. If your equipment lease or rental requires you to name the equipment lessor as an additional insured, please provide the name and address of the lessor as it appears on the lease or rental agreement:
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31. If your building lease requires the building owner to be included as an additional insured for the portion of the premises leased to you, please list the Lessor’s name and address as it appears on your lease:
-

32. Have you had any general liability losses in the past **three (3)** years?..... Yes No
 If “**Yes**”, provide date(s) of loss and detail(s).
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33. Do you want ERISA Fiduciary Liability coverage (\$100,000 Limit of Liability)?..... Yes No
 Coverage is recommended if you sponsor any Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-made basis.(Additional charges apply)

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of my policy.

I understand that, should my "Claims-Made" policy with this insurance carrier ever be cancelled or non-renewed, or I decide to terminate it for any other reasons, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Tennessee and Washington Residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont Residents only: which may be a crime and may be subject to civil fines and criminal penalties.)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Signature in full:

Date

REMINDER:

Please attach a sample of your letterhead and a copy of all of your dental practice "Yellow Pages" advertising, if any, to this application.

RETURN TO:		
State Administrator Name:		

Address:		

City:	State:	Zip Code:

Phone #: (_____) _____		
Agent's License Number: _____		

The Professional Protector Plan® is a registered trademark of B & B Protector Plans, Inc.®. Coverage is underwritten by Continental Casualty Company, one of the CNA property/casualty insurance companies. CNA is a service mark registered with the US Patent and Trademark Office.