



**Application for Newly Graduated Dental Students  
Entering Practice for the First Time**  
Type of Policy Requested:    Claims-Made    Occurrence

Complete all information as requested; use a "?" if you are not sure of an answer.

**Limits**     \$1,000,000 per claim/\$3,000,000 aggregate (Higher limits available upon request)

**Date you want your coverage to become effective**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Were you insured for your Board Exam through Brown/CNA Student Protector Plan?  Yes    No    Not Sure  
Month     Day     Year

**Your Name**

\_\_\_\_\_     \_\_\_\_\_     \_\_\_\_\_     \_\_\_\_\_  
First                                  Middle Initial                                  Last                                  Designation

**Mailing Address**  
(Where we can reach you within the next 90 days)

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

**Phone Number**

( \_\_\_\_\_ )                                  ( \_\_\_\_\_ )  
(Area Code) Day                                  (Area Code) Evening

**E-mail Address**

\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month     Day     Year

**Education**

\_\_\_\_\_  
Dental School Attended    Month/Year of Graduation

**History**

Have you ever practiced before?  Yes    No     (If "Yes", a full application must be completed prior to coverage approval. The application can be obtained from your State Administrator.)

Did you complete a residency?  Yes    No

Specialty: \_\_\_\_\_     Month/Year of Graduation: \_\_\_\_\_

**Your Practice**

Endodontics                                   Pedodontics                                   Public Health  
 General Dentistry                                   Periodontics                                   Faculty-Non Intramural  
 Orthodontics                                   Prosthodontics

**Business Structure**

Sole Proprietor                                   Partnership                                   Employee  
 Independent Contractor                                   Other: \_\_\_\_\_

**Practice Name and Address** (list State if you don't know where you will be practicing)

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Street    City     County     State     Zip Code  
( \_\_\_\_\_ )    ( \_\_\_\_\_ )  
Phone number (day)    Phone number (evening)

**Risk Management**

Have you taken one of the following risk management seminars?  CNA    Hartford  
 AAO    AAOMS    Princeton    NYSDA     Date of attendance \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Yes, If "Yes", provide proof of attendance  
 No, please send me information on how I can qualify for the risk management credit.

I hereby request that my application for insurance coverage under the provisions of the Professional Protector Plan® be submitted for consideration to the CNA Insurance Companies. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to the CNA Insurance Companies any and all information requested which may relate to my insurability under the Professional Protector Plan.

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 CNA to release the information on this application and associated underwriting information.

If you purchase a "Claims-Made" policy, the coverage will only respond to claims which are reported during the term of this policy. The "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of the policy.

If the "Claims-Made" policy with this insurance carrier is cancelled or non-renewed, or you decide to terminate it for any other reasons, and you 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, you will be able to purchase additional insurance coverage.

If you purchase an "Occurrence" policy, the coverage will only respond to claims which occur after the "Prior Acts Date" of this policy and before the end of the policy period, regardless of when the claims are reported.

If you have any questions, concerning the coverage for which you are applying, please contact your agent.

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.)

Signature in full: \_\_\_\_\_ Date: \_\_\_\_\_

<b>RETURN TO:</b>		
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 Plan, Inc.®. Coverage is underwritten by Continental Casualty Company, one of the CNA property/casualty insurance companies. CNA is a registered service mark and trade name of CNA Financial Corporation.

**NEW GRAD SUPPLEMENT      Professional Protector Plan**

Have you ever had a change in the status of hospital privileges?      yes      no

Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or any other regulatory agency?      yes      no

Have you ever been or are you currently being treated for alcoholism, drug addiction, mental illness or physical impairment?      yes      no

Are you now, or have you ever, practiced without professional liability insurance and/or had your professional liability insurance refused, cancelled or non-renewed?      yes      no

Has any claim or suit for alleged malpractice ever been brought against you?      yes      no

Has any governmental agency, including a state licensing board, ever taken any action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions?      yes      no

Have you ever been convicted of any criminal charges?      yes      no

Are you currently aware of any situation that could lead to a malpractice suit against you?      yes      no

**If you have answered “yes” to any of the above, please provide details on a separate sheet of paper.**

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Signature

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Date