TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Dentists & Oral Surgeons Professional Liability Insurance Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Verify that all requested explanations and documents are attached, including current declarations page and policy, CV and currently valued loss runs.

- Please complete this form electronically or type/print clearly and answer all questions.
- If you do not purchase Prior Acts Coverage from us you will not have coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.

ACCOUNT INFORMATION

1.	Applicant Name		
	Other Names Used		
	Gender	☐ Male ☐ Female	
	Degree / Title		
	Birth Date (MM/DD/YYYY)		
	Federal DEA #		
	National Practitioner ID #		
2.	Home Address	Street:	
		City:	State: Zip:
		County:	
		Phone:	Fax:
		Email:	
3.	Principal Office Address	Street:	
		City:	State: Zip:
		County:	
		Phone:	Fax:
		Email:	
		Website:	
4.	Other Office Address	Street:	
		City:	State: Zip:
		County:	
		Phone:	Fax:
		Website:	

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5. Type of Practice (check all that apply):

☐ Individual (solo) Unincorporated ☐ Individual (solo) Corporation ☐ Partnership

☐ Member of Multi-Person Corporation or Association ☐ Employee of: _____

☐ Other (describe): _____ ☐ Independent Contractor of: _____

6. List Federal Taxpayer Identification Number(s) and name(s) of Corporate entity(ies):

Entity: _____

Entity: _____

7. Please list names of all other partners, stockholders, associates, independent contractors and employed dentists or physicians. **(Indicate status of each and provide proof of coverage for each).**

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

Name: _____ Carrier: _____ Current Limits: _____

FINANCIAL AND EXPOSURE DETAILS

8. List all states where Applicant is licensed:

State: _____ License # _____

State: _____ License # _____

State: _____ License # _____

9. Dental Specialty:

☐ General Dental Practice ☐ Oral Surgery ☐ Orthodontics

☐ Dental Anesthesiology ☐ Oral/Maxillofacial Surgery

☐ Other (describe): _____

10. In what areas are you Board Certified or eligible?

Board Certified: _____ Date Certified: _____ ☐ N/A

Board Eligible: _____ Date Certified: _____ ☐ N/A

Have you ever failed any dental licensing or specialty organization examination? ☐ Yes ☐ No

If "Yes," please explain:

11. **Training**

Dental School: _____ Dates: _____ to _____

City: _____ State: _____ Country _____

Type of Residency: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country _____

Type of Residency: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country _____

Additional Medical Training:

Location	Type	Dates

Do you anticipate taking any additional residencies or changing your specialty? ☐Yes ☐No

If "Yes," please explain:

12. **Attestation**

If the answer to any of the following is "Yes," please give full details (including dates) on a separate sheet of paper:

a. Have you ever had professional liability insurance declined, canceled, issued on special terms or non-renewed? ☐Yes ☐No

b. Have you ever been or are you currently being investigated by a State Board of Dental Examiners, Board of Dental Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? (If "Yes," provide copies of all accusations, decisions, consent orders, etc.) ☐Yes ☐No

c. Has or is your license to practice dentistry or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ☐Yes ☐No

d. Have you ever had privileges at any hospital or other institution denied, reduced, revoked, restricted or suspended? ☐Yes ☐No

e. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics or any other substance abuse, sexual addiction, anger management issues, or any mental or emotional disorder? ☐Yes ☐No

f. Have you ever been arrested, indicted, pled guilty to, or been convicted of any crime other than minor traffic violations? ☐Yes ☐No

g. Has your membership in any professional society or association ever been refused, censured, suspended or revoked? ☐Yes ☐No

h. Do you currently have or have you ever had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice? ☐Yes ☐No

i. Are you currently or have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform your professional duties? ☐Yes ☐No

j. Has any dentist, patient or insurance plan ever filed a complaint against you with any Dental Association/Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? ☐Yes ☐No

k. Have you ever been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)? ☐Yes ☐No

13. Do you treat or review the treatment of prison inmates? ☐Yes ☐No

If "Yes:"

a. What percentage of your practice? _____%

b. Please explain and provide facility names:

c. Is insurance provided by the above facility? ☐Yes ☐No

14. Do you consult with or treat patients in any sovereign nation or territory, other than the U.S., such as Native American or Alaskan Native lands? ☐Yes ☐No

If "Yes:"

a. What percentage of your practice? _____%

b. Where?

15. Do you treat patients in any nursing home, skilled nursing facility or assisted living center? ☐Yes ☐No

If "Yes:"

a. What percent of practice? _____%

b. Do you treat patients other than your own? ☐Yes ☐No

16. List all locations where you have practiced in the last 10 years (include time period, group name and address).

Group Name	Street/City/State	During Years

17. How many:

a. Hours do you work per day? _____

b. Days do you work per week? _____

c. How many surgical procedures do you perform each week? _____

18. What is your average weekly patient load? _____

19. What percent of your patients are:

a. Over age 65? _____%

b. Age 18 or younger? _____%

c. Hospitalized patients? _____%

20. Do you or your professional entity employ or contract for the services of any healthcare personnel? ☐Yes ☐No

If "Yes," provide number of each and indicate if coverage (shared limits) is desired for each.

(Note: If employed by an entity, coverage may not be available.)

	Full-Time / Part-Time	# Employed	Is Coverage Desired?	# of Independent Contractors	Are they Insured?
Dentists					
Orthodontists					
Oral Surgeons					
CRNA's**					
Dental Hygenists					
X-ray Technicians					
Dental Technicians					
Laboratory Technicians					
Other (describe):					
Other (describe):					

**If employed or contracted, please submit a written explanation of practice and procedures performed, along with certificate of course completion and license number. Provide proof of insurance if insured elsewhere. If coverage is desired, please complete an Allied Personnel Professional Liability Insurance Application for each.

21. Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule? ☐Yes ☐No

If "Yes," have you implemented procedures to comply with the HIPAA Privacy Rule? ☐Yes ☐No

22. Has your practice (e.g. specialty, procedures or practice environment) changed in the last five years? ☐Yes ☐No

If "Yes," please explain:

23. Are you associated in any capacity with, or do you own any of the following:

a. A dental laboratory? ☐Yes ☐No

b. Any other business enterprise related to dentistry? ☐Yes ☐No

If "Yes," please explain:

24. Do you practice dentistry in any hospital, surgery center or other facility? ☐Yes ☐No

If "Yes," please list the facility or facilities where dentistry is performed:

Facility Name	City	State	Type of Privileges

25. For each procedure below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add each one under "Other" in each section.

A. General Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Orthodontic Full Mouth Banding				
Dental Implants				
Surgical Placement (explain):				
_____				
Prosthetic or Restorative				
Nerve Grafts				
Parotid Gland Surgery				
Orthognathic Surgery				
Management of Malignant Lesions				
Cleft Lip and Plate Surgery				
Face Lifts				
Rhinoplasty				
Sleep Apnea Therapy				
Intermaxillary Fixation for Obesity or Weight Control				
Sinus Lifts				
Root Canal Therapy				
Molar Endodontics				
TMJ Surgery				
TMJ Arthroscopy				
TMJ Reconstructive				
TMJ Implants				
Other (explain):				
_____				
Other Dental Surgery:				
_____				

B. Anesthesia Information:

Do you treat patients under any of the anesthetic modalities listed below?

(a) None ☐Yes ☐No

(b) Local Anesthesia ☐Yes ☐No

(c) Nitrous Oxide Analgesia ☐Yes ☐No

(d) Oral (swallowed) Conscious Sedation ☐Yes ☐No

(e) Parenteral Conscious Sedation (including intravenous or intramuscular) in a hospital, surgicenter or an office administered by a Dentist Anesthesiologist, M.D. Anesthesiologist or Oral Surgeon ☐Yes ☐No

(f) Parenteral Conscious Sedation (including intravenous or intramuscular) in a hospital, surgicenter or an office administered by you ☐Yes ☐No

(g) General Anesthesia – in a hospital, surgicenter or an office administered by a Dentist Anesthesiologist, M.D. Anesthesiologist or Oral Surgeon ☐Yes ☐No

(h) General Anesthesia – in a hospital, surgicenter or an office administered by you ☐Yes ☐No

(i) How many years have you used conscious sedation in your office? _____ Years

(j) How many years have you used general anesthesia in our office? _____ Years

(k) Do you hold a current ACLS Certificate? ☐Yes ☐No

(l) Are you and your staff certified in Basic Life Support (CPR)? ☐Yes ☐No

(m) Are the vital signs of your patients under sedation or general anesthesia being **continuously** monitored? ☐Yes ☐No

If "Yes," by whom?

☐You ☐CRNA ☐DDS Anesthetist ☐Other (explain):

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Remarks:

Which of the following methods do you use in monitoring patients?
Please indicate the appropriate codes based on mode of anesthesia:
(S) for Sedation, (G) for General Anesthesia or (B) for Both modalities:

_____ Manual Monitoring of blood pressure and heart rate
_____ Precordial Stethoscope
_____ Electronic/Automatic monitoring of blood pressure and heart rate
_____ EKG Monitor
_____ Pulse-Oximeter
_____ Other (Please specify):

Which of the following items do you have available for emergency treatment?

(a) Crash Cart ☐Yes ☐No
(b) Ambu Bag ☐Yes ☐No
(c) Oral Airway ☐Yes ☐No
(d) Oxygen ☐Yes ☐No
(e) Endotracheal Tubes/Scopes ☐Yes ☐No
(f) Emergency Drugs ☐Yes ☐No

CURRENT & REQUESTED COVERAGE

26. Requested Effective Date of Coverage: _____ Requested Retroactive Date of Coverage: _____

27. Do you intend to purchase a reporting endorsement (aka Tail Coverage) from your current insurer? ☐Yes ☐No

If "No," do you wish to obtain Prior Acts Coverage from us? ☐Yes ☐No

If applying for Prior Acts Coverage, please attach a copy of your most recent Declarations page and Policy.
(Prior Acts coverage is subject to Underwriter approval)

28. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

Carrier	Limits	Policy Period MM/DD/YYYY – MM/DD/YYYY	Claims Made or Occurrence	Retroactive Date (if applicable)	Premium

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CLAIMS INFORMATION

29. In the past, has the Applicant or any entity or individual proposed for coverage under this insurance, received or been involved in any claim, suit or medical incident that may fall within the scope of the proposed insurance? ☐Yes ☐No

If "Yes," please complete a **Claims Information Form** for each claim, suit or medical incident.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, SUIT OR MEDICAL INCIDENT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 29 IS EXCLUDED FROM THE PROPOSED INSURANCE.

30. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that my fall within the scope of the proposed insurance? ☐Yes ☐No

If "Yes," please complete a **Claims Information Form** for each fact, circumstance, situation, transaction, event, act, error or omission.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 30 IS EXCLUDED FROM THE PROPOSED INSURANCE.

CLAIMS INFORMATION FORM

(Please make additional copies if needed)

1. Name of Patient: 2. Age: 3. Gender: ☐M ☐F

4. Your relationship to patient:

5. Date of Incident: 6. Date Reported to Carrier: 7. Location:

8. Insurance Carrier(s):

9. Other Defendant(s):

10. Plaintiff's Counsel:

11. Defendant's Counsel:

12. Status: ☐ Incident Only ☐ Suit ☐ Closed If Closed, Date Closed:

Amount Paid: ☐ Settlement ☐ Judgement

13. Allegation(s) (as stated by patient/plaintiff):

14. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? ☐Yes ☐No

15. Condition and diagnosis at time of treatment:

16. Dates and description of treatment rendered:

17. Condition of patient subsequent to treatment (include DATES & FOLLOW UP TREATMENT):

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: X _____ Date: _____

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FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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

ARKANSAS, MINNESOTA AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS AND WEST VIRGINIA APPLICANTS: 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 civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MISSOURI APPLICANTS: Any person commits a “fraudulent insurance act” if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA APPLICANTS: 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK APPLICANTS: 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime 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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____ City: _____ State: _____ Zip: _____
Email Address	
Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____ City: _____ State: _____ Zip: _____

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.