GenStar

Reset Form

NEW BUSINESS APPLICATION

PROFESSIONAL LIABILITY

Dentists
Claims Made and Reported Coverage

Please complete this application and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

INSTRUCTIONS TO THE APPLICANT:

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The following additional information must be provided:
  - Copy of your current professional liability insurance Declarations page.
  - Copy of your Curriculum Vitae.
  - Copies of all advertising that you use.
  - Copy of your business letterhead.
  - Company loss runs, valued within the last 90 days.

I. GENERAL INFORMATION

1.	Applicant Name:	Date of Birth:
	Professional Designation: ☐ D.D.S. ☐ D.M.D. ☐ Other (describe):	
2.	Applicant Type: ☐ Individual ☐ Corporation ☐ Partnership ☐ LLC Employed Dentist - by whom: ☐ Other (describe):	
	Practice Type: ☐ Solo Practice ☐ Group Practice	
	Entity Name:	
	How many other dentists practice at this entity?	Applicant's percentage of ownership: %
	"Doing business as" (d/b/a) names used? If **YES**, specify:	☐ Yes ☐ No
	Do you want this entity covered?	☐ Yes ☐ No
3.	Mailing Address:	
	City:	County:
	State:	ZIP:
4.	Primary Practice Location:	Number years at location:
	City:	County:
	State:	ZIP:
	Do you have more than one practice location? If **YES**, please provide the following for each location: ☐ Yes ☐ No location address, hours of operation, procedures performed, number of years at location. Space provided at end of application.	
5.	E-mail:	Office Phone:
	Web Site:	Office Fax:
6.	Residence Address:	Residence Phone:
	City:	County:
	State:	ZIP:

II. DENTAL TRAINING and EDUCATION

1.	Dental Specialty:			
2.	Dental School:	City and State	Completed ☐ Yes ☐ No	Dates From / To
3.	Date you began practicing as a dentist:			
4.	If you are a foreign dental school graduate, please provide the date you began practicing in the United States:			
5.	Are you a U.S. citizen? If **NO**, please provide a copy of documents confirming your status.			☐ Yes ☐ No
6.	Are you American Dental Board certified in any specialty?			☐ Yes ☐ No
7.	Are you a member of any medical association? If **YES**, please list memberships:			☐ Yes ☐ No
8.	Please indicate the number of CME hours you have completed in the past two years:			

III. DENTAL PRACTICE HISTORY

1. Within the last five (5) years, have your practice characteristics, procedures performed, or business association(s) changed? If **YES**, please describe: ☐Yes ☐No

2. List all primary office locations where you have practiced in the last ten (10) years.(Use separate sheet if more space is needed)

Street Address & City	County	State	Dates – From / To

3. List all States where you practice or have a dental license: (Use separate sheet if more space is needed)

State	Medical License Number(s):	DEA License Number(s):	% of practice in each state:
			%
			%
			%

4. Legal / Professional / Administrative Actions against you:

a. Do you have hospital privileges? If so, where? ☐ Yes ☐ No

b. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? If **YES,** please explain: ☐Yes ☐No

c. Has your board certification or membership in any dental society/association ever been refused, suspended, revoked or voluntarily surrendered? If **YES,** please explain: ☐Yes ☐No

d. Has your dental license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? If **YES,** please explain: ☐ Yes ☐ No

e. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? If **YES,** please complete the **Substance Impairment Supplemental Application**. ☐ Yes ☐ No

f. Have you ever been charged with, or convicted of a crime other than minor traffic violations? If **YES,** please explain: ☐Yes ☐No

g. Have any fee or professional relations complaints been registered against you with your dental association(s), hospital(s), or a state licensing authority? If **YES,** please explain: ☐ Yes ☐ No

IV. OFFICE STAFF

1. Do you employ, contract with, or supervise any **physician(s), surgeons(s), or dentist(s)**? If **YES,** enter information below and attach current certificate(s) of insurance. ☐Yes ☐No

Physician/Surgeon/Dentist Name	Specialty	Limits of Liability	Employ (E) Contract (C) Supervise (S)	Insurer
			☐E ☐C ☐S	
			☐E ☐C ☐S	
			☐E ☐C ☐S	
			☐E ☐C ☐S	

2. Do you employ, contract with, or supervise any non-physician health care extenders? If **YES,** enter information below: ☐ Yes ☐ No

Type	Number Employed	Number Contracted	Carry Their Own Medical Malpractice Policy?	
Dental Assistants			☐Yes	☐No
Dental Hygienists			☐Yes	☐No
Dental Technicians			☐Yes	☐No
Nurse Anesthetists			☐Yes	☐No
Anesthesiologists			☐Yes	☐No
Other (Specify)			☐Yes	☐No

V. PROCEDURES/PRACTICE SPECIFICS

1. a. Average Weekly Patient Encounters:
   b. Average Weekly Practice Hours:

2. Please indicate your specialty. Check all that apply.

☐ General Dentistry	☐ Prosthodontics
☐ Endodontics	☐ Oral & Maxillofacial Surgeon
☐ Periodontics	☐ Orthodontics

3. Please provide the approximate percentage of your practice in the following:

Bone Grafting	%	Orthodonics	%
Cosmetic Dentistry		Pediatric Dentistry	%
Bonding	%	Periodonitics	%
Enamel Shaping	%	Prosthodontics	%
Full Mouth Restoration - Cosmetic Only	%	Prosthetics	%
Veneers	%	Fixed	%
Whitening with Lasers	%	Removable	%
Other Cosmetic procedure	%	Sleep Apnea	
Botox and dermal fillers	%	Surgery	%
Endodontics		Therapy	%
Single Rooted	%	Surgery	
Multi Rooted	%	Facial - Elective	%
Sargenti Root Canal Method	%	Head and Neck	%
General Dentistry		Oral/Maxillofacial	%
Simple Extractions	%	Other	%
Extractions of Partially or Bony Impacted	%	TMJ	
Implants		Non-Surgical	%
Restoration	%	Surgical	%
Placement	%	Other	%
		Total - 100%	

4. ANESTHESIA

a. Do you treat patients who are rendered unconscious BY YOU through the administering of anesthetics, analgesics, intravenous or intramuscular sedatives, or general anesthesia? ☐ Yes ☐ No
If YES, please explain:

b. Do you treat patients who are rendered unconscious BY OTHERS through the administering of anesthetics, analgesics, intravenous or intramuscular sedatives, or general anesthesia? ☐ Yes ☐ No
If YES, please explain:

c. Do you provide treatment to any patient who has been sedated with nitrous oxide? ☐ Yes ☐ No
If YES, does your equipment have FAIL-SAFE DEVICES? ☐ Yes ☐ No

d. Do you provide treatment to any patient who has been sedated with chloral hydrate? ☐ Yes ☐ No

e. Do you provide treatment to any patient who has been sedated with Halcion, Triazolam or other hypnotic drugs? ☐ Yes ☐ No
If YES: Mild Sedative? ☐ Yes ☐ No Unconscious State? ☐ Yes ☐ No

5 Do you own or operate a Laboratory? If **YES**, ☐ Yes ☐ No
a Does the laboratory provide services solely for your patients? ☐ Yes ☐ No
b If not limited to your patients, please explain:

6 a Are you now performing experimental or investigational procedures or prescribing/dispensing experimental drugs? If **YES**, please explain: ☐ Yes ☐ No

b Have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? If **YES**, please explain: ☐ Yes ☐ No

7 a Do you now treat prisoners in a State, Federal or any correctional institution? ☐ Yes ☐ No
b Have you ever treated prisoners in a State, Federal or any correctional institution? ☐ Yes ☐ No
If **YES**, please provide last date of treatment:

8 a Do you work in an Emergency Department? If YES, ☐ Yes ☐ No
b Is this solely to satisfy requirements for hospital privileges? ☐ Yes ☐ No
c Indicate the average number of hours you work in the Emergency Department each month:

9 a Are you a sports team physician or health care provider? ☐ Yes ☐ No
b If **YES,** check all that apply: ☐ High School ☐ College ☐ Professional ☐ Other:
Name and location of team(s):

10 a Do you treat patients in a Nursing Home or a similar care facility? If **YES**, ☐ Yes ☐ No
b How many patients currently reside in a Nursing Home or similar care facility?

11 Do you engage in tele-medicine activity? If **YES,** please describe the activity: ☐ Yes ☐ No

12 Do you prescribe drugs or provide diagnosis via the Internet? If YES, please describe: ☐ Yes ☐ No

13 Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc)? If YES, please describe: ☐ Yes ☐ No

VI. PRIOR POLICY and LOSS INFORMATION

1. Please provide the following information pertaining to your past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium	✳Total # of Claims
				☐CM ☐Occ	$	
				☐CM ☐Occ	$	
				☐CM ☐Occ	$	
				☐CM ☐Occ	$	
				☐CM ☐Occ	$	

✳Total # of claims, by carrier, regardless of payment, no-payment, dismissal or status.

2. Have you ever practiced without professional liability insurance? If **YES**, specify dates from and until: ☐ Yes ☐ No

3. Have you ever had any insurance company decline, cancel, rescind or non-renew any Professional Liability Insurance Policy? *(Response not required in the State of Missouri.)* If **YES**, please provide details: ☐ Yes ☐ No

4. Are you aware of any of the following:

a	Known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made?	☐ Yes ☐ No
b	A specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, that has not been reported to a prior insurance carrier?	☐ Yes ☐ No
c	Any request for dental records by a patient or his/her attorney which might result in a claim?	☐ Yes ☐ No
d	Information relating to service(s) on a Board which might result in a claim?	☐ Yes ☐ No
e	Any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, threat of claim, letter of intent, adverse result notice or attorney contact?	☐ Yes ☐ No
f	Any involvement, now or ever, in any Professional Liability claim or suit? If **YES,** a **Claim Information Supplemental Application** *must* be completed for each claim.	☐ Yes ☐ No

If **YES** to any of the above, please provide details:

VII. COVERAGE REQUESTED

NOTE: The Company may not offer or quote requested coverage.

Effective Date: Retroactive Date:

Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Limits of Liability:	☐ $ 100,000 / $300,000	**Deductible:**	☐ None
	☐ $ 200,000 / $600,000		☐ $ 5,000
	☐ $ 250,000 / $750,000		☐ $ 7,500
	☐ $1,000,000 / $3,000,000		☐ $10,000
	Other: $		Other: $

VIII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and

2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply)

☐ Part-time Supplemental Application	☐ Statement of No Known Claims Letter
☐ Claim Information Supplemental Application	☐ Other (specify):

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:

a	Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;

	b	Representations you are making on behalf of all persons and entities proposed to be insured;
	c	A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4	This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.	
5	You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.	

FRAUD WARNING

Notice to Applicants of all states except California, Kentucky, Louisiana, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Puerto Rico, Virginia and Washington D.C.:
Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties and denial of insurance benefits.

Notice to California Applicants:
For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Kentucky Applicants:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Notice to Louisiana 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 fines and confinement in prison.

Notice to 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.

Notice to New Mexico 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.

Notice to New York Applicants:
Any person who knowingly and with the 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 provision.

Notice to Oregon Applicants:
Any person who knowingly and with intent to defraud or deceive any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto upon which the insurance company or any other person relies may be a crime and may provide grounds for criminal or civil penalties.

Notice to Pennsylvania Applicants:
Any person who knowingly and with intent to defraud any insurance company or other person who, files an application for insurance or a 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.

Notice to Puerto Rico Applicants:
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars
($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established by be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to Virginia 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 include imprisonment, fines and denial of insurance benefits.

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

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE, IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

Signature of Applicant:	Date:
Print or Type Name and Title:	

ADDITIONAL INFORMATION	
Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.	
Section # and Question #	**Comments**
Signature:	Date: