



APPLICATION FOR DENTISTS AND ORAL SURGEONS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

- 1. (a) (i) Full name of Applicant:
(ii) Professional Degree:
(b) Principal practice address:
(c) Secondary practice locations:
(d) (i) Phone: (ii) Fax:
(iii) E-Mail Address: (iv) Website Address:
(e) (i) Date of Birth (MM/DD/YYYY): (ii) Place of Birth:
2. Are you a U.S. citizen?
3. (a) Type of practice:
(b) Do you want coverage for the entity named Item 3(a) above?
(c) Attach a copy of your letterhead.
(d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all others practicing under the entity name in Item 3(a)above.
4. Do you practice with any dentist not named in Item 3.(d) above?
5. Are you currently in active military service?

6. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. Federal DEA License No. and status: _____

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

<u>Name</u>	<u>City</u>	<u>State</u>	<u>Percentage of Work</u>	<u>Type of Privileges</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. Are you currently a hospital chief of staff or head of any hospital department? [] Yes [] No
If Yes, describe. _____

10. Do you or the entity firm named in Item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? [] Yes [] No
If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds. _____

11. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? [] Yes [] No
If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? [] Yes [] No

(ii) Provide the name and title of the Applicant's Privacy Officer. _____

Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. (a) Provide your dental specialty: _____

(b) Do you limit your practice to the specialty stated in item (a) above? [] Yes [] No
If No, provide details. _____

2. Are you American dental board certified in any specialty? [] Yes [] No

If Yes, provide the following: Board(s) in which you are certified: _____

Date of certification: _____ Any recertification date(s): _____

If No, do you plan on taking a Board examination? [] Yes [] No

3. Provide the following information:

	<u>Name of Institution</u>	<u>City</u>	<u>State</u>	<u>Date Completed</u>
Dental School	_____	_____	_____	_____
Internship – Specialty: _____	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Fellowship – Specialty: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

4. If you graduated from a foreign dental school, provide the date began your practice in the United States: _____

5. Provide a detailed summary of where you have practiced your profession since completing your training:

<u>Street Address</u>	<u>City, State</u>	<u>Country</u>	<u>From (MM/YY)</u>	<u>To (MM/YY)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

6. Indicate the professional organizations which you are a member of:

- | | |
|--|---|
| <input type="checkbox"/> American Association of OMS (AAOMS) | <input type="checkbox"/> American Society of Dentist Anesthesiologists (ASDA) |
| <input type="checkbox"/> American College of OMS ((ACOMS) | <input type="checkbox"/> State Society of OMS |
| <input type="checkbox"/> American Dental Association | <input type="checkbox"/> OMS Society – Other _____ |
| <input type="checkbox"/> Other (describe) _____ | |

7. How many hours of continuing dental or medical education have you taken within each of the last two (2) years? _____

III. SCOPE OF PRACTICE

1. Provide the approximate percentage of your practice in the following:

Bone Grafting	_____%	Microneurosurgical Procedures	_____%
Cosmetic Dentistry	_____%	Oral Pathology	_____%
Bonding	_____%	Oral Radiology	_____%
Enamel Shaping	_____%	Orthodontics	_____%
Full Month Restoration – Cosmetic Only	_____%	Orthognathic Procedures	_____%
Veneers	_____%	Pediatric Dentistry	_____%
Whitening with lasers	_____%	Periodontics	_____%
Other Cosmetic Procedures (describe) _____	_____%	Prosthodontics	_____%
Non-Dental Cosmetic Procedures (including		Prosthetics	
injecting Botox, collagen and fillers)(describe) _____	_____%	Fixed	_____%
		Removable	_____%
Endodontics	_____%	Sleep Apnea	_____%
Single Rooted	_____%	Surgery	_____%
Multi Rooted	_____%	Therapy	_____%
Sargenti Root Canal Method	_____%	Surgery	
General Dentistry		Facial – Elective Cosmetic	_____%
Extractions of Impacted Teeth	_____%	Head and Neck	_____%
Oral Surgery (describe) _____	_____%	Oral/maxillofacial	_____%
		Outside oral/maxillofacial region	_____%
Root Canal	_____%	(describe) _____	_____%
Simple Extractions Only	_____%	TMJ	_____%
Implants		Non-surgical	_____%
Restoration	_____%	Surgery	_____%
Placement	_____%	Other (describe) _____	_____%
		TOTAL	100%

2. Have you performed any implant procedures during the last 12 months?[] Yes [] No
If Yes, answer the following:

(a) Provide the number of procedures performed:

- Osseointegration only
- Endosteal (surgically inserted into the jawbone) _____
 - Mandibular Multi-quadrant – Ramus Frame _____
 - Other _____
- Subperiosteal (lie on top of jawbone but underneath gum tissue) _____
- Transosseus (penetrate entire jaw and emerge opposite the entry site) _____
- Other (describe) _____

(b) Do your dental records include written notes that a process of patient evaluation occurred prior to treatment?[] Yes [] No

(c) Do you perform any surgical procedures, such as sinus lifts, in conjunction with the placement of implants?[] Yes [] No

(d) Attach a copy of the informed consent forms and patient education materials that are given to patients prior to treatment.

3. Do you render any services outside the scope of your state's Dental Practice Act?[] Yes [] No
If Yes, describe. _____

4. Do you use written informed consent documents for all procedures?[] Yes [] No
If Yes, attached a copy of all form that are used. If No, attach an explanation.

5. Have you ever used a Proplast Viatek TMJ Implant in your practice?[] Yes [] No
 If Yes,
 (a) Have all such implants been replaced?[] Yes [] No
 (b) What is the date of the last implant? _____
6. Do you wire jaws closed for the purpose of weight loss?.....[] Yes [] No
 If Yes,
 (a) Number performed in the last 12 months: _____
 (b) Estimated number that will be performed in the coming year:_____
7. Has the nature of your practice, the type of procedures you perform or your use of anesthesia changed in the last 5 years?[] Yes [] No
 If Yes, provide details. _____
8. Do you have a surgical suite?[] Yes [] No
 If Yes, is your surgical suite certified?[] Yes [] No
 If Yes, provide the name of the certification body. _____
9. What percentage of your patients are under age 18? _____%
10. Do you perform any hospital emergency room care?[] Yes [] No
 If Yes, is this solely a requirement for active admitting privileges?[] Yes [] No
 If No, provide a detailed description including the approximate number of hours per month spent in emergency room care. _____
-
11. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering dental/medical services, dental/medical opinions or dental/medical advice?[] Yes [] No
 If Yes, provide the following:
 (a) Identify all states in which such patients reside: _____
 (b) What percentage of your total practice is involved in such activities? _____
12. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address?.....[] Yes [] No
 If Yes, identify all states in which such patients reside. _____
13. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery?[] Yes [] No
 If Yes, do you follow FDA-approved protocols?[] Yes [] No
 If Yes, describe. _____
-
- (b) Are you a Principal Investigator for any clinical trial?[] Yes [] No
14. (a) Indicate the number of professional employees in your practice for each of the following:
 (If none, check here [])
- | | | | |
|----------------------------------|----------------------------|--------------------------------------|------------|
| ___ Dentists other than yourself | ___ Hygienists | ___ Surgeon's Assistants* | ___ Nurses |
| ___ Dental Assistants | ___ Physicians | ___ Nurse Anesthetists* | |
| ___ Dental Technicians | ___ Physicians Assistants* | ___ Laboratory/Radiology Technicians | |
| ___ Other (describe) _____ | | | |
- *Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.
- (b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? [] Yes [] No
 If No, provide a detailed explanation on a separate page.
15. (a) Average weekly patient load: _____ (b) Number of patients annually: _____
16. Average number of hours you practice each week: _____
17. What is your approximate gross annual income from your practice? (Check one.)
- | | |
|----------------------------|---|
| ___ Less than \$50,000 | ___ \$50,000 to \$99,999 |
| ___ \$100,000 to \$149,999 | ___ \$150,000 to \$199,999 |
| ___ \$200,000 to \$499,999 | ___ \$500,000 or more (estimate) \$ _____ |

18. (a) Do you supervise anyone other than your own employees? [] Yes [] No
 If Yes, indicate by profession the number of individuals you supervise:

- Dentists other than yourself Hygienists Surgeon's Assistants* Nurses
 Dental Assistants Physicians Nurse Anesthetists*
 Dental Technicians Physicians Assistants* Laboratory/Radiology Technicians
 Other (describe) _____

* Attach protocols and description of the extent in which you supervise such persons.

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. _____

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? [] Yes [] No
 If No, provide a detailed explanation on a separate page.

19. If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **H** = Hospital **O** = Office **S** = Surgi-center or Certified Surgical Suite

	<u>Location</u>		<u>Location</u>
<input type="checkbox"/> Acupuncture	_____	<input type="checkbox"/> Hair Transplants or Suturing of Hairpieces	_____
<input type="checkbox"/> Adenoidectomy/Tonsillectomy	_____	<input type="checkbox"/> Laser Skin Resurfacing	_____
Anesthesia:		<input type="checkbox"/> Laser Surgery (describe) _____	_____
<input type="checkbox"/> General	_____	Liposuction – above the neck (specify volume) _____	_____
<input type="checkbox"/> Twilight	_____	Liposuction – below the neck:	
<input type="checkbox"/> Other – (describe) _____	_____	<input type="checkbox"/> under 3500 cc's volume	_____
Assisting in Surgery:		<input type="checkbox"/> 3500 cc's or more volume	_____
<input type="checkbox"/> Oral Surgery	_____	<input type="checkbox"/> Nerve Grafts	_____
<input type="checkbox"/> Other Surgery (describe) _____	_____	<input type="checkbox"/> Oral/Maxillofacial Surgery	_____
<input type="checkbox"/> Biopsies (describe) _____	_____	<input type="checkbox"/> Open Reduction of Fractures	_____
<input type="checkbox"/> Blepharoplasty	_____	<input type="checkbox"/> Pain Management (describe) _____	_____
<input type="checkbox"/> Cheek Implant	_____	Plastic Surgery:	
<input type="checkbox"/> Chemical Peel:		<input type="checkbox"/> Reconstructive Facial	_____
Solution Strength(specify) _____	_____	<input type="checkbox"/> Reconstructive - Other (describe) _____	_____
<input type="checkbox"/> Chin Surgery	_____	<input type="checkbox"/> Rhinoplasty	_____
<input type="checkbox"/> Cleft Lip and Palate Surgery	_____	<input type="checkbox"/> Radiation Therapy	_____
<input type="checkbox"/> Cosmetic implantation of silicone or other material	_____	<input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	_____
<input type="checkbox"/> Cosmetic Surgery	_____	<input type="checkbox"/> Sargenti Root Canal Method	_____
<input type="checkbox"/> Cryosurgery	_____	<input type="checkbox"/> Sinus Lift	_____
<input type="checkbox"/> Dental Alveolar Surgery	_____	<input type="checkbox"/> TMJ Surgery	_____
<input type="checkbox"/> Dermabrasion/Microdermabrasion	_____	<input type="checkbox"/> Uvulopalatoplasty	_____
Extractions:			
<input type="checkbox"/> Non-Impacted Teeth	_____		
<input type="checkbox"/> Impacted Teeth	_____		
<input type="checkbox"/> Face Lift	_____		

20. List your prior Professional Liability Insurance for each of the last (5) years, including the current year:

(a)	Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

- (b) Does the policy for the current year allow the reporting of any incidents or circumstances that are likely to result in a claim? [] Yes [] No
- (c) Do any of the above policies provide coverage for any:
 - (i) procedures not describes in this application and in which you no longer perform? [] Yes [] No
 - (ii) practice(s) not described in this application? [] Yes [] No

IV. ANESTHESIA INFORMATION

1. Is analgesia, sedation or anesthesia used on patients? [] Yes [] No
If Yes, answer the following:
 - (a) Local only [] Yes [] No
 - (b) Inhalation conscious sedation [] Yes [] No
If Yes, answer the following:
 - (i) Percentage of patients under age 18: ____%
 - (ii) Drugs used: [] Nitrous Oxide [] Other _____
 - (iii) Is sedation done in an office, surgi-center or hospital? _____
 - (iv) Administered by: [] You [] Oral Surgeon [] Physician Anesthesiologist
[] Dentist Anesthesiologist [] CRNA [] RN/LPN [] Other: _____
 - (c) Oral conscious sedation using drugs that are swallowed [] Yes [] No
If Yes, answer the following:
 - (i) Percentage of patients under age 18: ____%
 - (ii) List all drugs used: _____
 - (iii) Is sedation done in an office, surgi-center or hospital? _____
 - (iv) How long have you used conscious sedation in your office or surgical suite? _____
 - (v) Administered by: [] You [] Oral Surgeon [] Physician Anesthesiologist
[] Dentist Anesthesiologist [] CRNA [] RN/LPN [] Other: _____
 - (d) Parenteral conscious sedation (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 pharmacological or non-pharmacological method, or a combination thereof)..... [] Yes [] No
If Yes, answer the following:
 - (i) Percentage of patients under age 18: ____%
 - (ii) List all drugs used: _____
 - (iii) Is sedation done in an office, surgi-center or hospital? _____
 - (iv) How long have you used conscious sedation in your office or surgical suite? _____
 - (v) Administered by: [] You [] Oral Surgeon [] Physician Anesthesiologist
[] Dentist Anesthesiologist [] CRNA [] Other: _____
 - (e) Parenteral deep sedation (a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including inability to respond purposely to verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof)..... [] Yes [] No
If Yes, answer the following:
 - (i) Percentage of patients under age 18: ____%
 - (ii) List all drugs used: _____
 - (iii) Is sedation done in an office, surgi-center or hospital? _____
 - (iv) Administered by: [] You [] Oral Surgeon [] Physician Anesthesiologists
[] Dentist Anesthesiologist [] CRNA [] Other: _____

(f) General anesthesia (a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to verbal command, produced by a pharmacological or non-pharmacological method, or a combination thereof).....[] Yes [] No
If Yes, answer the following:

- (i) Percentage of patients under age 18: _____%
- (ii) List all drugs used: _____
- (iii) Is sedation done in an office, surgi-center or hospital? _____
- (iv) How long have you used general anesthesia in your office or surgical suite? _____
- (v) Administered by: [] You [] Oral Surgeon [] Physician Anesthesiologist
[] Dentist Anesthesiologist [] CRNA [] Other: _____

(g) Are Harvard Standards for the administration of all anesthesia adhered to?[] Yes [] No
If No, explain. _____

- 2. (a) Have you completed an ACLS course?[] Yes [] No
- (b) Do you hold an ACLS certificate?[] Yes [] No
If Yes, what is the expiration date? _____
If No, are you currently CPR Certified?[] Yes [] No
- (c) Is any member of your operating staff currently CPR certified?[] Yes [] No

3. Check all that apply:

- (a) Have you completed an ADA-accredited general anesthesia program of one year or longer?[] Yes [] No
- (b) Did your oral surgery training include 6 or more months of training in general anesthesia?.....[] Yes [] No
- (c) Have you taken at least two years of anesthesia training following dental school for certification as an anesthesiologists?.....[] Yes [] No

4. Are vital signs of your patients under sedation or general anesthesia continuously monitored?[] Yes [] No
If Yes, by whom? [] You [] CRNA [] Dentist Anesthesiologist [] Other: _____

5. If you use any of the following methods to monitor patients, indicate by using **S** for sedation, **G** for general anesthesia or **B** for both.

- ___ Manual monitoring of blood pressure and heart rate
- ___ Precordial stethoscope
- ___ Electronic/automatic monitoring of blood pressure and heart rate
- ___ EKG monitor
- ___ Pulse oximeter
- ___ Other (describe) _____

6. Which of the following items do you have available for emergency treatment? Check all that apply.

- ___ Oral airway ___ Ambu bag ___ Endotracheal tubes/scopes
- ___ Oxygen ___ Emergency drugs

7. Does the state you practice in require you to hold a current certificate/permit to administer general anesthesia or intravenous sedation?[] Yes [] No
If Yes, provide the following:

Certificate number: _____ Date of renewal: _____

V. AFFILIATIONS

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3(a) above?[] Yes [] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3(a) above?[] Yes [] No
If Yes, provide a detailed explanation including a description of your responsibilities. _____

- If Yes, does any contract contain a hold harmless agreement? [] Yes [] No
 If Yes, attach a copy of the contract.
3. Are you in the employ of or under contract to any governmental entity? [] Yes [] No
 If Yes, provide a detailed explanation including a description of your responsibilities. _____
-
4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? [] Yes [] No
 If Yes, attach a copy of all advertisements.
5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? [] Yes [] No
 If Yes, attach a copy of the advertisement or applicable website address.
6. Are you the Dental/Medical Director of a nursing home, clinic, commercial enterprise or any other organization? [] Yes [] No
 If Yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position. _____
-
7. Do you have any administrative or teaching responsibilities? [] Yes [] No
 If Yes, provide the following and attach a copy of any contract or agreement:
- (a) Name of entity and location: _____
 Your title _____
- (b) Does the entity provide you coverage for:
 (i) Your administrative responsibilities? [] Yes [] No
 (ii) Your direct patient care? [] Yes [] No
8. Do you work for any locum tenens companies? [] Yes [] No
 If Yes, attach a copy of your Certificates of Insurance.
9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? [] Yes [] No
 If Yes, provide details. _____
10. Are you engaged in or planning to engage in any "moonlighting" activities? [] Yes [] No
 If Yes, do you want coverage for your "moonlighting" activities? [] Yes [] No
 If Yes, describe the activities. _____

VI. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? [] Yes [] No
 If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? [] Yes [] No
 If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.
3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? ... [] Yes [] No
 If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.
4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? [] Yes [] No
5. Has 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
6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? [] Yes [] No
7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? [] Yes [] No

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? [] Yes [] No
9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? [] Yes [] No

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant

Title

Signature of Applicant

Date

Notice to 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 the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS



amesco
of New Jersey

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for us

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED:



SUPPLEMENTAL CLAIM INFORMATION

APPLICANT'S INSTRUCTIONS:

- 1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

- 1. Applicant Name
2. Claimant Name
3. Name of Individual(s) at your firm/Company involved in Claim:
4. Indicate whether: Claim/Suit Incident
5. Date of alleged error: Date claim made against applicant:
6. Additional defendants:
7. Current Disposition of claim:
[] DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
[] ABANDONED (no activity from claimant for over 3 years)
[] WON by defense
[] WON by claimant Total Paid \$ Amount Paid on your behalf \$
Indicate whether: [] Court judgment, or [] Out of court settlement
[] OPEN Claimant's settlement demand \$
Defendant's offer for settlement? \$ Insurer's loss reserve \$
8. Name of Insurer:
9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
a. Alleged act, error or omission upon which Claimant bases claim:
b. Description of cases and events:
c. Description of the type and extent of injury or damage allegedly sustained:
d. If a medical claim provide type of injury claimed:
[] Emotional Only [] Temporary Disability [] Death [] Cosmetic
[] Permanent Disability [] Other (describe)
10. Explain what action has been taken by you to prevent recurrence of the same type of claim.

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Name of Applicant* Title (Officer, partner, etc.)

Signature of Applicant Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.