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Glastonbury, CT 06033
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Fax: 800.403.3580
www.integrisgrp.com

Dentists & Oral Surgeons Professional Liability Application

This application will be incorporated into the policy if coverage is bound. All questions must be answered accurately and completely. Please call your insurance representative if you have any questions.

Instructions:

A. Please print or type text directly into the application (PDF Format).
B. Answer all questions leaving no blanks.
C. Check all boxes that apply. If any questions, or part thereof, do not apply, state N/A in the space.
D. If space is insufficient to answer any question fully, attach a separate sheet of paper.
E. This application must be completed, dated and signed by the applicant.
F. Include copies of loss runs for the past 10 years (or back to retroactive date, whichever is longer), dated within the last 90 days. Provide complete details for any losses paid. Do not indicate patient identifiers or any personal identifiable health information.
G. Attach copy of your curriculum vitae.
H. Attach a copy of your medical license.
I. Attach a copy of your Declaration Page from your current policy.

I. APPLICANTS PERSONAL INFORMATION

Name of Applicant:

First: _____ Last Name: _____ Middle Initial: _____ Title: _____

DOB: _____ Gender: ☐M ☐F

Home Address:

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Email: _____

Mailing Address:

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Primary Office Address:

Employer/Group Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Office Manager: _____

Email: _____

Billing Address (if different than Mailing address):

Address: _____

_____

City: _____ State: _____ Zip Code: _____

II. COVERAGE INFORMATION

Desired Effective Date: _____

Desired Retroactive Date: _____

☐ Board Certified ☐ Board Eligible ☐ Other

Date of Certification: _____

Date of Recertification: _____

NPI #: _____

Medical License #: _____ Expiration Date: _____

DEA License #: _____

Controlled Substance #: _____

Medical Specialty: _____

Sub-Specialty: _____

Name of Specialty Board: _____

1. Have you ever applied to Integris Insurance Company in the past? ☐Yes ☐No

2. How many hours per week do you practice? _____

3. Do you have a position for which no coverage is required under the Integris Insurance Company policy or which you are already otherwise insured? ☐Yes ☐No
If Yes, provide the name of the hospital or other institution that provides the coverage and initial employment date.

Hospital/Institution: _____ Initial Employment Date: _____

4. Names of business(es) which you own or for whom you work - include names under which you are doing business (DBA):

Name: _____ Location: _____

Name: _____ Location: _____

5. Do you practice out-of-state or interpret films or tests of patients from out-of-state? ☐Yes ☐No

If Yes, where? _____

a. How many hours per week do you practice out-of-state? _____
b. Percentage of your total practices out-of-state? _____
c. How many patients per week do you see out-of-state? _____

6. **Coverage**: ☐ Claims Made ☐ Occurrence

7. **Limits of Liability** (please click on the limits that apply to your practice)

☐ **Connecticut**

Dental Limits:	☐ $500,000/$1,500,000	☐$1,000,000/$3,000,000	☐$1,000,000/$4,000,000
Oral Surgery Limits:	☐ $500,000/$1,500,000	☐$1,000,000/$4,000,000	☐$2,000,000/$5,000,000

☐ **Massachusetts**

Dental/Oral Surgery Limits:	☐ $1,000,000/$2,000,000	☐$1,000,000/$3,000,000	☐$2,000,000/$6,000,000

III. CURRENT PRACTICE INFORMATION

1. Please indicate your practice type:

☐ Solo Unincorporated or Independent Contractor ☐ Partner
☐ Sole Shareholder Corporation ☐ Professional Corporate Shareholder
☐ Employee of a group or individual ☐ Other: _____ (Please State)

2. Name of corporation, solo corporation, partnership, DBA or employer, if applicable: _____

3. Is coverage for your corporation or partnership desired? ☐ Yes ☐ No If Yes, please complete Corporation/Partnership Application.

4. Specialty (Please click on the specialty and check the boxes that apply to your practice)

Dentist Specialties

☐ General Dentistry	☐ Orthodontics	☐ Oral Pathology	☐ Other _____
☐ Dual Specialty	☐ Pediatric Dentistry	☐ Anesthesiology Dental:	
☐ Endodontics	☐ Periodontics	☐ Conscious Sedation	
☐ Public Health	☐ Prosthodontics	☐ General Sedation	

Oral Surgeon Specialties

☐ Dual Specialty	☐ Oral/Maxillofacial Surgery	☐ Anesthesiology Dental:	☐ Other _____
☐ Prosthodontics	☐ Oral Pathology	☐ Conscious Sedation	
	☐ Public Health	☐ General Sedation	

5. How many patients do you treat per week in your office? _____ In the hospital? _____

6. Please check the box next to the organization of which you are a member:

☐ Connecticut Dental Association ☐ American Association of Oral and Maxillofacial Surgeons

☐ American Dental Association ☐ Other _____

7. List any changes you have made in your practice within the past five years (i.e. new procedures, part-time) _____

_____

8. Does your office have all oxygen, drugs and appropriate equipment to properly manage emergencies that may occur as a result of procedures or tests performed in your office? ☐ Yes ☐ No
   a. Are you currently certified in: ☐ Basic Life Support for the Professional Rescuer ☐ Advanced Life Support
   b. Is your office staff trained in: ☐ Basic Life Support for the Professional Rescuer ☐ Advanced Life Support

IV. PERSONNEL INFORMATION

1. If you own your own practice:

Number of Employee Dentists	Full-time _____ / Part-time _____	Attach proof of professional liability insurance
Number of Independent Contractor Dentist(s)	Full-time _____ / Part-time _____	
Number of Non-Dentist employees	Full-time _____ / Part-time _____	
Number of Dental Hygienists	Full-time _____ / Part-time _____	
Total Number	Full-time _____ / Part-time _____	

V. EDUCATION INFORMATION

If no Curriculum Vitae is attached then complete this section:

1. Name and Location of Dental School: _____ Year: _____

2. Subject and location of dental/oral surgery residency(ies):

_____ From: _____ To: _____

_____ From: _____ To: _____

_____ From: _____ To: _____

3. Date residency completed: _____

4. Date fellowship completed: _____

Name all the places where you have practiced (excluding residency or fellowship training):

_____ From: _____ To: _____

_____ From: _____ To: _____

_____ From: _____ To: _____

VI. EMERGENCY BACKUP

1.	Are your staff members trained in first aid procedures	☐Yes	☐No
2.	Are procedures in place to provide aid to injured parties in the event of an emergency?	☐Yes	☐No
3.	Do you have arrangements in place with emergency medical facilities?	☐Yes	☐No
4.	Is your office within 10 miles from a hospital, clinic, or other medical facility?	☐Yes	☐No

VII. RATING INFORMATION

1. Indicate which of the following applies to your practice:

☐ No general or local anesthesia, analgesia or sedation

☐ Local anesthesia only

☐ Local anesthesia and/or nitrous oxide/oxygen analgesic

☐ Parenteral conscious (including I.M. and I.V. sedation in office)

How often is this administered? ☐ daily ☐ monthly ☐ yearly

Connecticut State Parenteral Conscious Sedation Permit #: _____ Exp. Date: _____

Date of last on-site evaluation: _____

☐ General Anesthesia in office

How often is this administered? ☐ daily ☐ monthly ☐ yearly

Connecticut State General Anesthesia and Conscious Sedation Permit #: _____ Exp. Date: _____

Date of last on-site evaluation: _____

Who, other than yourself, administers anesthesia in your office? _____

☐ General anesthesia or parenteral conscious sedation in a hospital or accredited surgi-center where anesthesia is under the supervision of an anesthesiologist or CRNA.

☐ Other, describe (i.e. acupuncture, hypnosis): _____

2. Which of the following TMJ therapies do you perform: (Check all that apply)

☐ Initial Examination ☐ TMJ Radiography ☐ TMJ Disorder Referrals ☐ Biopsies

☐ TMJ Surgery ☐ Comprehensive TMJ Therapy ☐ TMJ Disorder Palliative Therapy

Describe specialized TMJ therapy training and duration of training you have received:

_____

3. Which of the following endodontic procedures do you perform: (Check all that apply)

☐ "Conventional" Gutta Percha ☐ Thermafil or Thermafil-like ☐ Apicoectomies

☐ Sargenti or Sargenti-like ☐ All Endodontics Referred

4. Which of the following tooth replacement implant procedures do you perform: (Check all that apply)

☐ Surgical placement of implants ☐ Restorative treatment of implants ☐ All Endodontics Referred

Describe specialized training, duration of training and type of implants used: _____

5. Which of the following surgical procedures do you perform: (Check all that apply)

☐ Erupted third molars extractions ☐ Periodontal surgery ☐ Biopsies

☐ Cosmetic surgical procedures ☐ Extraction of partially or fully impacted third molars

VIII. PRACTICE INFORMATION

(If yes, to questions 1 through 7, please provide additional information including loss estimates or payment amounts on a separate sheet. Please sign and date the information)

1.	Have you ever been convicted of, pleaded guilty or no contest to, any violation of a law or ordinance other than minor traffic offenses?	☐Yes	☐No
2.	Have you ever been treated for alcoholism or drug addiction?	☐Yes	☐No
3.	Do you now or have you ever had any chronic physical defect or any mental or emotional illness or disorder, which impaired or could adversely affect your ability to practice chiropractic medicine to any degree?	☐Yes	☐No
4.	Have you ever signed a consent order or consent agreement with, or been investigated by, a state health department, state licensing board or other governmental body?	☐Yes	☐No
5.	Have you ever practiced without malpractice insurance or had it canceled, non-renewed, denied or offered to you only on special or restricted terms?	☐Yes	☐No
6.	Has your license to practice ever been revoked, suspended or subjected to probation?	☐Yes	☐No
7.	Do you have a relationship with a radiologist who over reads your x-rays?	☐Yes	☐No

IX. CLAIMS INFORMATION

*Please note that the use of **claim** or **suit** in this application is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation*

1. Are you or have you been involved in a malpractice claim or suit, either directly or indirectly? If yes, please indicate total number of claims and suits: _____ Open _____ Closed A Claim Addendum may be requested for open claims or suits.	☐Yes ☐No
2. Have all claims and suits been reported to your current or prior professional liability carrier?	☐Yes ☐No ☐N/A
3. Are you aware of any of the following circumstances regarding medical care you provided:	
A. A letter or request for records from a patient or a patient's attorney or representative related to an adverse outcome from care you provided to a patient?	☐Yes ☐No
B. A statement by or letter from a patient or patient's representative expressing dissatisfaction or questioning the quality or timeliness of any care you provided to a patient?	☐Yes ☐No
C. A statement by or letter from a patient or patient's representative claiming a failure to provide care on your part or failure to diagnose?	☐Yes ☐No
D. Intra- or post-procedural complications or other treatment complications resulting in death, paralysis, loss of body part or bodily function, disability, re-operation or extended hospitalization or other morbidity?	☐Yes ☐No
E. Any death (expected or otherwise), neurological, sensory, or systematic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing, loss of limb, or other morbidity from care you provided whether or not you believe that medical standards of care were met?	☐Yes ☐No
F. Any permanent damage related to an injury during delivery of child or administration of anesthesia?	☐Yes ☐No
G. Has a patient, patient's representative or representative filed any compliant or grievance to any healthcare institution, institution at which you practice and/or managed care organization of which you are a member, regarding care you provided to a patient?	☐Yes ☐No
H. Has a patient, patient's representative or any healthcare institution filed any governmental report (including Department of Public Health, and other state or federal agency) or grievance regarding care you provided to a patient?	☐Yes ☐No
I. Has your care ever been the subject of a peer review, sentinel event report or other investigation by any healthcare institution?	☐Yes ☐No
J. Are you aware of any expression of dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you whether from a patient or a patient's family or representative?	☐Yes ☐No
K. Have all circumstances that might reasonably lead to a medical incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐Yes ☐No ☐ None to Report

X. ASSIGNMENT OF POLICY RIGHTS

I assign to my employer or professional entity the right to cancel my policy and/or change my coverage terms and to receive any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc.).

This may be revoked by me at any future time by sending written notice to Integris Insurance Company. _____ Initials

XI. WARRANTY: PRIOR KNOWLEDGE OF FACTS/ CIRCUMSTANCES/SITUATIONS

For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Virginia, Washington, and West Virginia residents ONLY: the title of this section and any other reference to "WARRANTY" is deleted and replaced with "Applicant Representation."

No person or entity proposed for coverage is aware of any fact, circumstance or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage: NONE, or except

_____.

Without prejudice to any other rights and remedies of the Company, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed in response to this section, any claim or action based on, arising from, or in consequence of such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Company.

XII. DISCLOSURE AUTHORIZATION

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes thereto between the Company and any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance for the purpose of confirming my coverage (including their employees, officers, agents, directors and other representatives). This authorization does not create any obligation for the Company to release or exchange such information.

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made by me herein (and their employees, officers, agents, directors and other representatives) to release such information to the Company and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues.

I AUTHORIZE the Company and such representatives to use a copy of this authorization in place of the original. This authorization shall be valid for one year from the date signed. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

XIII. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES

The Applicant's submission of this Application does not obligate the Company to issue, or the Applicant to purchase, a policy. The Applicant will be advised if the Application for coverage is accepted. The Applicant hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

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

Notice to 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 and may be subject to fines and confinement in prison.

Notice to Arkansas, New Mexico 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to 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.

Notice to District of Columbia 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.
Notice to 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.

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 and Rhode Island 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 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.

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 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. Notice to 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.

Notice to 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.

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 with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may 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 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.

Please read the following carefully, and initial below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. I AGREE to notify Integris Insurance Company (the "Company") promptly of any material changes in the information I have provided herein. I UNDERSTAND that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

_____
Initials

Signature of Applicant:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Signature of Broker or Authorized Representative:

Print Name: _____ License #: _____ Date: _____

Signature: _____ Company: _____

Instructions for using editable Applications and Important Legal Information:

1. Save the document to your local computer.
2. Complete the application by providing your responses in the areas provided; utilize the tab key to move ahead to the next field.
3. If there is not enough space for any particular question, please include the full response in an additional attachment to your application, as you would if you were completing a paper-based application.
4. When you have completed the application, please verify the application for accuracy and completeness before signing the application and forwarding the application to your agent or broker. Do not forward applications directly to Integris Insurance Company unless you are an agent or broker.
5. If you choose to sign the application with a wet signature, please print the final application, sign the application in ink and forward the application to your agent or broker with any necessary supporting materials.
6. If you apply your signature to this form electronically, you hereby consent and agree that your use of a key pad, mouse or other device to click the "I Agree" button constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand. Further, you agree that the lack of a certification authority or other third party verification will not in any way affect the validity or enforceability of your signature or any resulting contract. You can apply your signature electronically by clicking on the signature field. Once all signatures have been applied, forward the application to your agent or broker via email. Any necessary supporting materials should be sent via email or postal service to your agent or broker.

IF YOU ARE ACCESSING THE DOCUMENT FROM A VENUE OTHER THAT WWW.INTEGRISGRP.COM, BY YOUR USE OF THE DOCUMENT, YOU ARE AGREEING TO THE FOLLOWING, IF YOU DO NOT AGREE, DO NOT USE THE ELECTRONIC DOCUMENT:

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* Integris Insurance Company is not responsible for any versions of the document that have been manipulated, altered or revised from the version of the document that appears on www.integrisgrp.com. Do not post the document on the Internet.

Integris Insurance Company is a member of the Integris Group of Companies.

Insured's Name: _____ Date: _____

Insured's Signature: _____