RLA Insurance INTERMEDIARIES

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: _____
(Street) (County)

_____
(City) (State) (Zip)

(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? ..... [ ] Yes [ ] No
If No, what is your status in the U.S. and current citizenship? _____

3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
[ ] professional corporation* [ ] professional association*
[ ] limited liability company* [ ] partnership*
[ ] employee of _____ [ ] independent contractor of _____
[ ] other _____
* Specify name of entity: _____

(b) Do you want coverage for the entity named Item 3(a) above? ..... [ ] Yes [ ] No

(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? ..... [ ] Yes [ ] No
If Yes, provide the name of each dentist and the practice relationship. _____

_____

5. Are you currently in active military service? ..... [ ] Yes [ ] No

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

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

7. Federal DEA License No. and status: _____

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

Name	City	State	Percentage of Work	Type of Privileges

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.markelcorp.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:

	Name of Institution	City	State	Date Completed
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:

Street Address	City, State	Country	From (MM/YY)	To (MM/YY)

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

[ ] American Association of OMS (AAOMS)
[ ] American College of OMS ((ACOMS)
[ ] American Dental Association
[ ] Other (describe) _____
[ ] American Society of Dentist Anesthesiologists (ASDA)
[ ] State Society of OMS
[ ] OMS Society – Other _____

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	____%
_____	____%	Prosthetics	
Non-Dental Cosmetic Procedures (including injecting Botox, collagen and fillers)(describe)		Fixed	____%
		Removable	____%
_____	____%	Sleep Apnea	
Endodontics		Surgery	____%
Single Rooted	____%	Therapy	____%
Multi Rooted	____%	Surgery	
Sargenti Root Canal Method	____%	Facial – Elective Cosmetic	____%
General Dentistry		Head and Neck	____%
Extractions of Impacted Teeth	____%	Oral/maxillofacial	____%
Oral Surgery (describe)_____		Outside oral/maxillofacial region	
_____	____%	(describe)_____	____%
Root Canal	____%	TMJ	____%
Simple Extractions Only	____%	Non-surgical	____%
Implants		Surgery	____%
Restoration	____%	Other (describe) _____	____%
Placement	____	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

	Location		Location
___ Acupuncture	_____	___ Hair Transplants or Suturing of Hairpieces	_____
___ Adenoidectomy/Tonsillectomy	_____	___ Laser Skin Resurfacing	_____
Anesthesia:		___ Laser Surgery (describe)_____	_____
___ General	_____	Liposuction – above the neck (specify volume) _____	_____
___ Twilight	_____	Liposuction – below the neck:	
___ Other – (describe) _____	_____	___ under 3500 cc's volume	_____
Assisting in Surgery:		___ 3500 cc's or more volume	_____
___ Oral Surgery	_____	___ Nerve Grafts	_____
___ Other Surgery (describe) _____	_____	___ Oral/Maxillofacial Surgery	_____
___ Biopsies (describe)_____	_____	___ Open Reduction of Fractures	_____
___ Blepharoplasty	_____	___ Pain Management (describe) _____	_____
___ Cheek Implant	_____	Plastic Surgery:	
___ Chemical Peel: Solution Strength(specify) _____	_____	___ Reconstructive Facial	_____
___ Chin Surgery	_____	___ Reconstructive - Other (describe) _____	_____
___ Cleft Lip and Palate Surgery	_____	___ Rhinoplasty	_____
___ Cosmetic implantation of silicone or other material	_____	___ Radiation Therapy	_____
___ Cosmetic Surgery	_____	___ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	_____
___ Cryosurgery	_____	___ Sargenti Root Canal Method	_____
___ Dental Alveolar Surgery	_____	___ Sinus Lift	_____
___ Dermabrasion/Microdermabrasion	_____	___ TMJ Surgery	_____
Extractions:		___ Uvulopalatoplasty	_____
___ Non-Impacted Teeth	_____		
___ Impacted Teeth	_____		
___ 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
(1)					
(2)					
(3)					
(4)					

(5) _____

(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 it's 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

SUPPLEMENTAL FOR DENTAL COSMETIC PROFESSIONAL LIABILITY INSURANCE (if applicable)

Notice: The policy for which application is made applies only to "Claims" first made during the "Policy Period". The limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible, unless the policy is amended by endorsement. 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: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (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? ..... [ ] Yes [ ] No
   If No, what is your status in the U.S. and current citizenship? _____

3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
   [ ] professional corporation** [ ] professional association**
   [ ] limited liability company** [ ] partnership**
   [ ] employee of _____ [ ] independent contractor of _____
   [ ] other _____
   * Specify name of entity: _____
   (b) Do you want coverage for the entity named Item 3(a) above? ..... [ ] Yes [ ] No
   (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? ..... [ ] Yes [ ] No
   If Yes, provide the name of each dentist and the practice relationship. _____

   _____

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

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

6. Federal DEA License No. and status: _____

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

If Yes,

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

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

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

II. OPERATIONS

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:

Completed	Name of Institution	City	State	Date
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. Have you practiced continually for the last ten (10) years, except for any military leave? ..... [ ] Yes [ ] No

   If No. explain._____

III. PROFESSIONAL SERVICES

1. List all manufactured equipment and drugs used in the Applicant's practice and the purpose for which each is used. Attach separate sheet if necessary.

Equipment/Drug	Purpose	Used only as approved by the FDA? (Yes or No)	If No, describe off-label usage.

2. Does the Applicant take before and after pictures of every patient? ..... [ ] Yes [ ] No

   If No, explain. _____

   ____

3. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment? ..... [ ] Yes [ ] No

   If No, explain. _____

IV. PROCEDURES

1. Botox Injections

   Does the Applicant perform Botox Injections? ..... [ ] Yes [ ] No

   If Yes, complete the following:

   (a) Total number of Botox Injections: .....(i) Last 12 months: _____ (ii) Next 12 months: _____

   (b) Who performs Botox Injections? .....

   ___ Physician ___ Physician's Assistant ___ Nurse

   ___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Botox Injections:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ..... [ ] Yes [ ] No

(ii) Performed a minimum of ten procedures on live patients? ..... [ ] Yes [ ] No

2. Chemical Peels

Does the Applicant perform Chemical Peels? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Chemical Peels with solution strength <30%: (i) Last 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength <30%:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(ii) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specifically for this procedure including anatomy, physiology, skin typing, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ..... [ ] Yes [ ] No

(b) Total number of Chemical Peels with solution strength >30%: (i) Last 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength >30%:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

3. Dermal Fillers

Does the Applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Dermal Fillers: .....(i) Last 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Dermal Fillers?

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Dermal Fillers:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ..... [ ] Yes [ ] No

(ii) Performed a minimum of five procedures on live patients? ..... [ ] Yes [ ] No

(d) Does the Applicant:

(i) Use only dermal fillers approved by the FDA? ..... [ ] Yes [ ] No

If No, explain: _____

(ii) Disclose off-label use to all patients receiving such treatment on the patient consent form?... [ ] Yes [ ] No

4. Laser Skin Treatments

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, and Laser Vein Treatments? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Laser Skin Treatments: .....(i) Last 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Laser Skin Treatments Injections?

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Does the Applicant comply with the following standards of practice:

(i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. ..... [ ] Yes [ ] No

(ii) Prior to the initiation of any patient care activity the individual has read and sign the clinic's policies and procedures regarding the safe use of lasers. ..... [ ] Yes [ ] No

(iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) ..... [ ] Yes [ ] No

(iv) A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented..... [ ] Yes [ ] No

(v) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician. ..... [ ] Yes [ ] No

(d) Does the Applicant comply with the following standards of practice for non-dentist use of laser related technology:

(i) Any dentist who delegates a procedure to a non-dentist must be qualified to do these laser procedures themselves by virtue of having received appropriate training in physics, safety, surgical techniques, pre and post operative care, and be able to handle the resultant emergencies or sequela. ..... [ ] Yes [ ] No

(ii) Any licensed medical professional employed by a dentist to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice. ..... [ ] Yes [ ] No

(iii) A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site dentist supervision and following written procedures. ..... [ ] Yes [ ] No

(iv) The supervising dentist is available on-site to respond to any untoward event that may occur. Ultimate responsibility lies with the supervising physician. ..... [ ] Yes [ ] No

5. Massage Therapy/Cellulite Treatments

Does the Applicant perform Massage Therapy/Cellulite Treatments? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Massage Therapy / Cellulite Treatments: .(i) Last 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Massage Therapy / Cellulite Treatments?

___ Physician ___ Physician's Assistant ___ Nurse
___ Massage Therapist ___ Nurse Practitioner ___ Other-describe: _____

(c) Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements? ..... [ ] Yes [ ] No

If No, explain. _____

6. Mesotherapy and/or Lipodissolve

Does the Applicant perform Mesotherapy and/or Lipodissolve? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Mesotherapy/Lipodissolve Treatments: ....(i) Last 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Mesotherapy/Lipodissolve at this clinic?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Are all staff performing Mesotherapy and/or Lipodissolve licensed dentists with a minimum of eight hours training to perform Mesotherapy and/or Lipodissolve including anatomy, physiology, contraindications, potential complications, and performance of at least one procedure on each part of the anatomy for which coverage is desired? ..... [ ] Yes [ ] No

7. Microdermabrasions

Does the Applicant perform Microdermabrasions? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Microdermabrasions: .....(i) Last 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Microdermabrasion:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Microdermabrasion treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? ..... [ ] Yes [ ] No

If No, explain: _____

8. Micropigmentation / Permanent Makeup

Does Applicant perform Micropigmentation / Permanent Makeup? ..... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Permanent Makeup / Micropigmentations: (i) Last 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Permanent Makeup / Micropigmentations:

_____ Physician ___ Physician's Assistant ___ Nurse
_____ Dentist ___ Nurse Practitioner ___ Other-describe:

(c) Have all staff performing Permanent Makeup / Micropigmentation treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? [ ] Yes [ ] No
If No, explain: _____

9. Sclerotherapy Injections

Does the Applicant perform Sclerotherapy Injections? ..... [ ] Yes [ ] No
If Yes, complete the following:
(a) Total number of Sclerotherapy Injections: .....(i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs Sclerotherapy Injections?
_____ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____
(c) Are all staff performing Sclerotherapy Injections dentists who have received a minimum of eight hours training specific for this procedure, including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of a minimum of one procedure on a live patient? ..... [ ] Yes [ ] No

10. Tattoo Removals

Does the Applicant perform Tattoo Removals? ..... [ ] Yes [ ] No
If Yes, complete the following:
(a) Total number of Tattoo Removals: .....(i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs Tattoo Removal:
_____ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____
(c) Are all staff performing Tattoo Removal licensed dentists who comply with the following standards of practice:
(i) Dentists are trained appropriately in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. ..... [ ] Yes [ ] No
(ii) Prior to the initiation of any patient care activity the dentist has read and signed the clinic's policies and procedures regarding the safe use of lasers. ..... [ ] Yes [ ] No
(iii) Continuing education of all dentists is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) ..... [ ] Yes [ ] No

11. Surgical or Minor Surgical / Invasive Procedures

Does the Applicant perform surgical or minor surgical/invasive procedures? ..... [ ] Yes [ ] No
If Yes, complete the following:
(a) Total number of surgical procedures: .....(i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs surgical and/or minor surgical/invasive procedures?
_____
(c) Provide a complete list of all surgical and minor surgical/invasive procedures being performed: Attach a separate sheet if necessary.
_

V. CLAIMS AND HISTORY

1. 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
(1)					
(2)					
(3)					
(4)					
(5)					

(b) Does the policy for the current year allow the reporting of any incidents or circumstances that .....are likely to result in a claim?
(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

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance?.....
   If Yes, how many? _____Complete a copy of our Supplemental Claim form for each one.

3. 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.

4. 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.

5. 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

6. 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

7. 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

8. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance?
   [ ] Yes [ ] No

9. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders?..... [ ] Yes [ ] No

10. 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

VI. ADDITIONAL INFORMATION

As part of this Application, attached the following:

1. A copy of training certificate for each procedure in Section IV., Procedures, that the Applicant performs.

2. A copy of consent formed for each procedure in Section IV., Procedures, that the Applicant performs.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a Claim or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any Claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are 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 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 and 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.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

(i) the policy for which this application is made applies only to "Claims" first made during the "Policy Period";

(ii) unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

(iii) unless amended by endorsement, "Claim Expenses" shall be applied against the "Deductible".

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 30 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

SUPPLEMENTAL CLAIM INFORMATION (for each claim)

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.