

## What you need to know about PSIC's Professional Liability Insurance Coverage

### **Professional liability insurance coverage is available in two forms: Occurrence Coverage and Claims Made Coverage.**

**Occurrence Coverage** provides coverage for injuries that occur during the policy period regardless of when the claim is reported. Claims may be reported in writing at any time during the active policy period or after the policy expires, is cancelled or non-renewed.

**Claims Made** coverage provides coverage for incidents that occur and are reported in writing on or after the **retroactive date** of the policy, and before the policy expires, cancels or non-renews. Upon cancellation, you have the option to purchase an Extended Reporting Endorsement or "Tail Coverage," which will allow claims to be reported for an indefinite period of time after the policy period is no longer active, as long as the injury occurred on or after the retroactive date and before the policy expired, non-renewed or was cancelled. Note: The extended reporting endorsement may not be available if your policy cancels for non-payment of premium.

The **retroactive date** defines the date coverage begins and after which claims may be reported once your policy is in effect. The retroactive date is stated on the Declarations Schedule and can be concurrent with the effective date of the policy, or a date other than the effective date of the policy, upon which you and we agree coverage will be effective. However, if you purchased an extended reporting endorsement from your current carrier, your prior policy was an occurrence policy, or you have had a gap in coverage, the retroactive date will be concurrent with the effective date of the new claims made policy.

If your expiring policy was a **Claims Made** policy, and you now desire an **Occurrence** policy, you have the option to apply for **Prior Acts Coverage**. This will allow claims to be reported for an indefinite period of time after your previous policy is no longer active, as long

as the injury occurred on or after the retroactive date that you and we agree on and before your previous policy expired, non-renewed or was cancelled. Your occurrence policy will be made effective the date your previous claims made policy expired, non-renewed, or was cancelled and any claims resulting from future injuries will be handled under the terms and conditions of the occurrence policy. Note: Your application must be received prior to the cancellation of your previous policy to be eligible for Prior Acts Coverage.

### **Effective Date of Coverage**

Upon approval of your application, your policy effective date may be no earlier than the day your completed application is received by Professional Solutions Insurance Company. If you choose to fax your application, the earliest effective date will be the day after it is received.

### **Corporation Coverage Options**

- **Sole Practitioner:** Provides coverage with shared limits of liability to the corporation for claims that arise from professional services rendered by the insured. **This option does not provide coverage to the corporation for the acts of any other licensed professionals and is offered at no additional charge.**

- **Separate Limits:** Provides coverage with separate limits of liability to the corporation for claims that arise from professional services rendered by the insured. An additional premium of 10% of the total undiscounted base premium for each insured dentist listed on the Declarations Schedule will be applied for this coverage.

Corporation coverage will not apply to any **injury** or **incident** arising from an act, error, or omission in the rendering or failure to render **professional services** by any professional who is not an insured dentist.

• **Multiple Corporations:** Provides for an insured dentist with multiple partnerships, corporations or professional associations. A separate limit is available for all eligible corporations on a shared basis. The premium will be 10% of the total undiscounted base premium for each insured dentist listed on the schedule for the primary corporation and an additional 5% for each additional corporation.

## **Application Checklist**

- ✓ Include a copy of your most recent declarations page from your previous carrier.
- ✓ Include a copy of all active licenses you hold.
- ✓ If applying for corporation coverage please include a coverage declaration page for each licensed professional practicing with your corporation.
- ✓ Include a 10-year loss run from your current and prior insurance companies.

**Please completely fill out all areas on the application. If any areas do not apply, please state, "N/A."**

# Request for Malpractice Protection

To help with timely approval of your request for coverage, please complete all questions and provide any additional requested documentation as indicated. If information provided isn't complete, coverage approval may be delayed or declined. If your answer to any question is "NONE" or "NOT APPLICABLE," please write "N/A."

## Section A – GENERAL INFORMATION

1. Name: \_\_\_\_\_  

LAST
FIRST
MIDDLE INITIAL
2. Designation(s) (DDS, DMD, etc.): \_\_\_\_\_
3. Social Security No: \_\_\_\_ - \_\_\_\_ - \_\_\_\_      Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Gender:  Male  Female
4. Name of Practice: \_\_\_\_\_  
 This practice is a:  DBA (doing business as)     Legal Entity (if "legal entity," please complete section D)
5. Practice Address: \_\_\_\_\_  

STREET
CITY
COUNTY
STATE
ZIP
6. Home Address: \_\_\_\_\_  

STREET
CITY
STATE
ZIP
7. Billing Address: \_\_\_\_\_  

STREET
CITY
STATE
ZIP
8. Do you practice in more than one location? .....  YES     NO  
**✓ If "yes," please provide details on a separate sheet.**
9. Number of years at current practice address: \_\_\_\_\_
10. Where would you like mail sent?     Practice Address     Home Address     Billing Address
11. Office Phone: ( \_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_ ) \_\_\_\_\_ Home Phone: ( \_\_\_\_ ) \_\_\_\_\_
12. Email Address: \_\_\_\_\_ Website Address: \_\_\_\_\_  
Your email address will never be shared or sold. It will be used to send you important notices.
13. Name of institution where you received your dental education/training: \_\_\_\_\_
14. Years attended: From \_\_\_\_\_ To \_\_\_\_\_
15. Graduation Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Original License Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

16. Year you began practicing dentistry: \_\_\_\_\_

17. List all states where you currently practice, the license number, date of license expiration, and the percent you practice in each:

LICENSE NUMBER	STATE	EXPIRATION DATE	% OF PATIENTS SEEN IN STATE

✓ Please attach a copy of each active license you hold. Total must equal 100%

18. Professional associations to which you belong:  ADA  ACD  State Dental  Other \_\_\_\_\_

**Section B — COVERAGE INFORMATION**

1. Type of insurance requested:  Claims Made  Occurrence

2. Effective Date requested: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

When your application is approved, your policy effective date can be on or after the day your completed application is received by Professional Solutions Insurance Company. If you choose to fax your application, the earliest effective date will be the day after it's received.

3. Desired Limits of Coverage (*per incident/per policy year*):

- \$2 million/\$4 million                       \$500,000/\$1 million                       \$200,000/\$600,000
- \$1.1 million/\$3 million                       \$250,000/\$750,000                       \$100,000/\$300,000

4. Are you requesting retroactive coverage from Professional Solutions Insurance Company?..  YES  NO

5. Please provide the following information regarding your professional liability insurance for the past five years:

INSURANCE COMPANY	DATES OF COVERAGE	CLAIMS MADE OR OCCURRENCE	POLICY LIMITS	IF CLAIMS MADE, WAS TAIL PURCHASED?	DEDUCTIBLE
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	

✓ Please provide a copy of your current/expiring Declarations page.

6. Are you required to name an additional insured for professional liability coverage? .....  YES  NO

a. If "yes," please provide the name, address, relationship/reason for each and the number of hours affiliated annually:

\_\_\_\_\_

**Section C — PRACTICE INFORMATION**

1. What type of business is your current practice?  
 Individual/Solo Practice  
 Partner or Shareholder in a legal entity (LLC, PC, S-Corp etc.)  
 Employee (Employer Name: \_\_\_\_\_)  
 Independent Contractor  
 Dental School Graduate with a limited permit (only limits available are \$100,000/\$300,000)  
 Dental Laboratory  
 Mobile Dental Practice  
 Government Employee or work at a government facility  
Please explain your practice profile: \_\_\_\_\_  
 Other: \_\_\_\_\_

2. On average, are your office hours less than 20 per week including lab work, patient care/consultation and patient records? .....  YES  NO  
a. Please list your office hours: \_\_\_\_\_  
b. Total number of patients you see weekly: \_\_\_\_\_

3. Do you share dental facilities with another medical professional? .....  YES  NO  
**✓ If "yes," please attach proof of professional liability insurance for all.**

4. Has there been any change in your practice or specialty in the past 5 years? .....  YES  NO  
a. If "yes," please describe: \_\_\_\_\_

5. If you are a faculty member, please list the Institution(s): \_\_\_\_\_  
\_\_\_\_\_

6. If you have hospital privileges, please indicate the name and location of each hospital where you hold staff or courtesy privileges (and please provide a copy of your hospital privileges from each):
- | HOSPITAL NAME | CITY, STATE |
|---------------|-------------|
| _____         | _____       |
| _____         | _____       |

**✓ If you do not currently have hospital privileges, attach the protocol you have in place if your patient requires hospital admission, including the names of physicians willing to accept your patients for admission.**

7. Do you discuss and document informed consent prior to treating all patients? \_\_\_\_\_  YES  NO  
8. Do you have a transfer plan for emergency situations that may occur in your office? *See question 6 above* .....  YES  NO  
9. Do you keep documented records of all treatment performed on patients, their responses and your treatment plans? .....  YES  NO

**Section D — CORPORATION/ENTITY INFORMATION**

- 1. Are you the owner or the majority shareholder of a corporation/legal entity?.....  YES  NO
- 2. Is the purpose of your corporation or partnership dental in nature?.....  YES  NO
- 3. Do you have malpractice coverage for this entity under another policy? .....  YES  NO  
 **If "yes," please attach a copy of that policy's Declarations page.**
- 4. Do you want coverage for your corporation/legal entity under this policy? .....  YES  NO  
 **If "yes," please complete # 5-7. If "no," write N/A in the spaces below and skip to section E.**

5. Please provide legal name of entity \_\_\_\_\_

6. Date of incorporation \_\_\_\_/\_\_\_\_/\_\_\_\_ Federal Tax ID No. : \_\_\_\_\_

7. OWNER	% OF OWNERSHIP
_____	_____
_____	_____
_____	_____

- 8. Do you employ, contract, and/or share space with any other licensed dentists?.....  YES  NO  
 **If "yes," please provide name, designation, and affiliation (e.g., employee, independent contractor, etc):**

NAME	DESIGNATION/JOB TITLE	AFFILIATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

**IMPORTANT NOTE:** Please provide a copy of the Declarations page showing proof of coverage for each individual not applying for coverage with Professional Solutions Insurance Company (PSIC).

- 9. Please review the cover page of the application titled "What you need to know about PSIC's Professional Liability Insurance Coverage" (Corporation Coverage Options) to determine the entity coverage option that applies to your practice.

Please indicate which type of corporation coverage you request below.

**Sole Practitioner (Shared Corporation Limits):**— Available if your entity does not employ any other licensed health care providers (dentists).

**Separate Limits**

Are you requesting coverage for additional corporations (of which you are the majority owner/partner)?..... YES  NO

**If "yes," please list each entity and all the owners, indicating the percentage of ownership for each.**

Additional Entity name: \_\_\_\_\_

OWNER	% OF OWNERSHIP
_____	_____
_____	_____
_____	_____

**If additional entities, please provide details on a separate sheet.**

**Section E — EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE**

▶ Please include a copy of your CURRENT CV outlining your education, training, continuing education and professional experience to date.

- 1. Have you completed a residency or any additional training in a dental specialty? .....  YES  NO
✓ If "yes," please list month and year of completion, specialty and where training or residency took place:

MONTH YEAR LOCATION OF TRAINING OR RESIDENCY SPECIALTY

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

- 2. If you are a graduate of a dental school outside the United States, are you certified by your practicing State Board of Dental Examiners?.....  YES  NO

- 3. Are you currently enrolled in a Patient Compensation Fund (PCF)? .....  YES  NO
✓ If "yes," please list states: \_\_\_\_\_

- 4. Do you ever prescribe or dispense prescription drugs? .....  YES  NO

- 5. Have you been asked to participate in or have you volunteered to participate in an alcohol or drug addiction program? .....  YES  NO
✓ If "yes," please attach a copy of your recovery plan document.

▶ If you answer "yes" to any question between 6 and 13, please outline details of the situation on a signed and dated separate sheet and provide copies of applicable court or board documents.

- 6. Are you now, or have you ever, practiced without professional liability insurance?.....  YES  NO

- 7. Have you ever been declined, canceled, or refused issuance or renewal for malpractice insurance? .....  YES  NO
NOTE: MO residents need not respond to this question.

- 8. Has your professional dental license ever been suspended, restricted, revoked or voluntarily surrendered, or has probation ever been invoked? .....  YES  NO

- 9. Have you ever been the subject of disciplinary proceedings or reprimanded by an administrative agency, hospital or professional association? .....  YES  NO

- 10. Has any hospital ever denied, restricted, suspended or revoked your privileges; or have you ever voluntarily surrendered your privileges? .....  YES  NO

- 11. Have you ever been convicted of, pleaded guilty or no contest, to any violation of a law or ordinance other than a minor traffic offense?.....  YES  NO

- 12. Do you have any health problems (or any type of disability) which might affect your practice of dentistry? .....  YES  NO

- 13. Are you aware of possible malpractice claims that have not yet been brought against you? .....  YES  NO

If you answer "yes" to question 14, 15 or 16, please provide details on the Past Claim Information Form attached and provide loss information from your previous insurance company.

14. Have you had any malpractice claims in the past 10 years?.....  YES  NO  
 ✓ If "yes," please provide details on the attached Past Claim Information Form and provide details and loss information from your previous insurance company.
15. Has any claim or suit for alleged sexual misconduct ever been brought against you?.....  YES  NO  
 ✓ If "yes," please provide details on attached Past Claim Information Form.
16. Have you reported any incidents or claims to a previous insurance company which have not been resolved?.....  YES  NO  
 ✓ If "yes," please provide details on attached Past Claim Information Form.

**Section F — TREATMENT INFORMATION**

1. Please review the Dental Class Descriptions for D1, D2, and D3 below and indicate which class best describes your practice.

**DENTAL CLASS D1**

- ▶ Members of Class D1 may perform simple extractions.
- ▶ Members may treat with local anesthesia and oral medication as well as conscious sedation via nitrous oxide or oxygen.

**DENTAL CLASS D2**

- ▶ Members of Class D2 may:
  - extract soft-tissue impactions.
  - perform implant dentistry, including implant restoration, implant surgery, or extraction of bony impactions a **combined total of 100 or fewer times per year**.
  - treat with local anesthesia and oral medication as well as conscious sedation via nitrous oxide or oxygen.
  - perform dentistry using general anesthesia or deep sedation within or outside of a hospital or state licensed and regulated surgical center only if anesthesia is administered by a licensed provider of anesthetic services, other than the insured.

**DENTAL CLASS D3**

- ▶ Members of Class D3 may:
  - perform implant dentistry, including implant restoration, implant surgery, or extraction of bony impactions a **combined total of more than 100 times per year**.
  - treat with local anesthesia and oral medication as well as conscious sedation via nitrous oxide or oxygen.
  - perform dentistry using general anesthesia or deep sedation within or outside of a hospital or state licensed and regulated surgical center only if anesthesia is administered by a licensed provider of anesthetic services, other than the insured.

2. Please indicate the areas of practice and the percentage of time for each that apply to best describe your current practice. In addition, please answer the following procedure questions.

A. Areas of Practice:	% OF PRACTICE	% OF PRACTICE	
General Dentistry .....	_____ %	Public Health Dentistry .....	_____ %
Endodontics .....	_____ %	Oral/Maxillofacial Radiology .....	_____ %
Forensic Dentistry .....	_____ %	Oral Pathology .....	_____ %
Pediatric Dentistry (Child) .....	_____ %	Orthodontics .....	_____ %
Periodontics .....	_____ %	Sports Dentistry .....	_____ %
Prosthodontics .....	_____ %	Cosmetic Dentistry* .....	_____ %

**B. Procedures**

Please list Cosmetic Dentistry procedures provided: \_\_\_\_\_

\* Cosmetic Dentistry requires evidence of continuing education in this field of dentistry and does not include non-dental cosmetic procedures.

- Do you perform apicoectomies or periradicular services?..... YES  NO
- Do you perform Periodontic surgical services (CDT codes D4210 – D4276)?..... YES  NO
- Do you perform surgical excision of intra-osseous lesions (CDT codes D7440 – D7461)?.... YES  NO
- Do you manufacture maxillofacial prosthetics?..... YES  NO
  - For your own patients? ..... YES  NO
  - For patients other than your own patients? ..... YES  NO
  - Do you have a manufacturing lab on-site? ..... YES  NO

- Do you offer TMJ treatment:
  - Phase I (non-surgical) ..... YES  NO
  - Phase II (surgical) ..... YES  NO

- What type of implants do you use?
  - Endosteal/Eposteal/Transosteal ..... YES  NO
  - Subperiosteal/ Ramus frame .....  YES  NO

- Do you treat sleep apnea:
  - Non-invasive ..... YES  NO
  - Invasive..... YES  NO
  - If yes, please list: \_\_\_\_\_

- Do you operate a mobile dental practice? ..... YES  NO
- If yes, please provide the following on a separate sheet:

- What types of services are provided?
- What equipment and staff do you bring with you?
- What emergency procedures are in place?
- Geographic area and patient demographics.
- Do you obtain a parent/guardian signature for treatment of minors?

3. Please indicate if you provide/administer any of the following, and if so, what %:

Procedures:	% OF PRACTICE	% OF PRACTICE	
<input type="checkbox"/> IV Conscious Sedation .....	_____%	<input type="checkbox"/> Smoking Cessation .....	_____%
<input type="checkbox"/> General Anesthesia/Deep Sedation .....	_____%	<input type="checkbox"/> Hypnosis .....	_____%
<input type="checkbox"/> Facial Liposuction .....	_____%	<input type="checkbox"/> Tattooing .....	_____%
<input type="checkbox"/> Sargenti Technique.....	_____%	<input type="checkbox"/> Other Non-dental Cosmetic Procedures (please list) .....	_____%
<input type="checkbox"/> Hair Replacement .....	_____%		
<input type="checkbox"/> Weight Loss Therapy .....	_____%		

**▶ IMPORTANT NOTE: The procedures in number 3 above will be excluded under the PSIC policy. Practices that have a total of 50% or more of above procedures are not eligible for coverage.**

✓ **If you indicated that your practice includes Sports Dentistry, please provide a copy of your referral protocols for patients who present with a sports-related injury that is not dental-related, but that occurred during a dental/ facial injury.**

4. Please list any other dental techniques that will help PSIC better understand any special circumstances concerning your practice:

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**Section G — BILLING INFORMATION**

Choose your billing frequency:       Annually       Semi-Annually       Quarterly

**Section H — SIGNATURE REQUIRED**

**Insurance coverage becomes effective upon approval of the application and issuance of the policy. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT. Acceptance of the premium does not constitute approval of the application.**

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection.

By signing this application the applicant authorizes the company to conduct any and all necessary background investigations in support of this application of insurance.

When you provide a check, you authorize us to use information from your check to make a one-time electronic funds transfer from your account. When we use your check to make an electronic funds transfer, funds may be withdrawn from your account on the same day we receive your check and you will not receive your check back from your financial institution.

**X**

\_\_\_\_\_

SIGNATURE

**X**

\_\_\_\_\_

DATE

For residents of all states except New York, New Jersey, Virginia and Washington:

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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

New York residents:

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 state value of the claim for each such violation.

New Jersey residents:

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

Virginia and Washington residents:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

# Past Claim Information

Complete this form ONLY if you have had professional liability or professional discipline claims brought against you.

**Please photocopy this form as needed.**

1. Patient's Name: \_\_\_\_\_  
PLEASE PRINT CLEARLY

2. Date of incident from which claim or suit resulted or is likely to result: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. Date claim was made against you: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4. Allegations made against you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Explain, in detail, the specifics of the incident which led to the claim: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Present status or disposition of claim including amount reserved or amount of settlement or judgment, if any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Claim filed in: State \_\_\_\_\_ Court \_\_\_\_\_  
Claim No. \_\_\_\_\_

8. What insurance company is involved? \_\_\_\_\_

9. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claims or suit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you need additional space for claim information, please check here and include details on a separate sheet.

**X** \_\_\_\_\_  
SIGNATURE

**X** \_\_\_\_\_  
DATE