Professional Liability/Medical Malpractice
Preferred • Standard • Non-Standard

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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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 by call (502) 244-1056. 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)