ALLIED MEDICAL DENTAL PROFESSIONAL SUPPLEMENTAL APPLICATION

Submit with Allied Medical General Application

Every statement MUST be completed. Write "NONE" if that applies. PLEASE TYPE OR PRINT.

SECTION I: GENERAL INFORMATION (To be completed by all applicants) Agent______________________________

1. Full Name ____ Male Female Date of Birth
   Last First M.I.

2. Home Address ________________________________ City______________________ State ___________ Zip________

3. Mailing Address _______________________________ City______________________ State ___________ Zip________
   (If different from home address)

4. Home Telephone (____) __________________ Professional Degree_________ Lic# _____________ State__________

5. I practice as:

   Solo Practitioner - UNINCORPORATED Revenue $ ____________________________________

   EMPLOYEE or INDEPENDENT CONTRACTOR (List name of each employer)_____________________________

   PARTNERSHIP (List name of partners) * ____

   PROF. CORP. or PROF. ASSN. (List name of corp. & principals) * _____________________________________

____

*** All members of a partnership as well as all shareholders of a professional corporation who practice dentistry must be covered under**

6. Character of Practice: General Endodontics Oral & Maxillofacial Surgery Oral Pathology Orthodontics Pedodontics Periodontics Prosthodontics Other __________________________________

SECTION II: COVERAGE REQUEST

1. Plan of Insurance Desired:

   Occurrence Claims Made Bridge

2. Requested Limits of Liability:

   $100,000/$300,000 $200,000/$600,000
   $500,000/$1,500,000 $1,000,000/$3,000,000

3. Requested Effective Date: ____/____/____

4. *Requested Retroactive Date: ____/____/____
   *To be completed by all applicants who are leaving an existing claims made program. Refer to the declarations page of your policy to determine the retroactive date.
   Attach a copy of the current declarations page showing the retroactive date.

5. List Your Professional Liability Insurance carrier for each of the **last five (5) years.** If none, state NONE.

Inception Date	Expiration Date	Name of Insurance Company	Policy Number	Premium	Limits of Liability

SECTION III: PRIOR EXPERIENCE

Yes No 1. Has there ever been a claim or suit, settled or pending, made against you for malpractice and/or peer review?
If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.

Yes No 2. Do you have reason to believe that your past treatment of, or failure to treat a patient may result in a claim or suit against you or any dentist associated in practice with you?
If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.

Yes No 3. Has any claim or suit ever been brought against any dentist associated in practice with you as a result of alleged malpractice, error or mistake?
If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.

Yes No 4. Have you ever appeared before the state licensing agency for professional misconduct?
If "Yes," please provide a copy of the board's findings.

Yes No 5. Has any disciplinary action been taken by **or** a complaint lodged with, a government agency, hospital, or professional association against you or any of the past or present principals, partners or officers, or any dentist associated with you ?
If "Yes," please provide a copy of the complaint and the final order and/or stipulation:

Yes No 6. Have you ever been refused board certification?
If "Yes," please give details:____
____

Yes No 7. Has any insurance company ever declined, failed to renew, or cancelled a Professional Liability Policy for you?
If "Yes," please list company, date, and reason:____
____

8. How many suits for collection of fees have been filed by you during the past two years?____

SECTION IV: PROFILE OF PRACTICE

1. How many locations do you practice at?__________________ Complete the following for each location. **(Space is provided for two (2) locations. If you are involved in more than two (2) locations, please copy as needed.)**

a. Name of Facility ____

b. Street Address____________________________________City________________________State________Zip________

c. County________________________________Phone (_______)___________________Fax (___)___________________

d. What is your professional relationship with this facility? **(Check all that apply)**
Owner Employee Independent Contractor Manager Supervisor Director
Other (please explain) ____

e. Time spent at this location: Days per week_____________________________Hours per week_____________________

f. How many dentists, **(excluding yourself)**, are engaged in practice at this location? _____________________________

g. For each of these dentists provide their specialty and hours per week spent practicing at this location:

Specialty	Hours per week	Specialty	Hours per week

h. Except as to referrals to specialists, are you solely responsible for the treatment and follow-up care for your patients?
Yes **No. If "No," please explain:** ____
____

a. Name of Facility ____

b. Street Address____________________________________City________________________State________Zip ________

c. County________________________________Phone (____)___________________Fax (____)_____________________

d. What is your professional relationship with this facility? **(Check all that apply)**

Owner Employee Independent Contractor Manager Supervisor Director

Other (please explain) ____

e. Time spent at this location: Days per week________________________Hours per week_______________________

f. How many dentists, **(excluding yourself)**, are engaged in practice at this location? ___________________________

g. For each of these dentists provide their specialty and hours per week spent practicing at this location:

Specialty	Hours per week	Specialty	Hours per week

h. Except as to referrals to specialists, are you solely responsible for the treatment and follow-up care for your patients?
Yes **No. If "No," please explain:** ____
____

2. Dental School Attended_____________________________________ Year Graduated_______ Year Licensed_______

Yes No 3. Do you employ any dentists as employees or independent contractors?
If "Yes," how many? _____________________

Yes No a. Are any of these employees or independent contractors oral and maxillofacial surgeons?

Yes No b. Do any of these employees or independent contractors treat patients with general anesthetics, intravenous or intramuscular sedatives?

Yes No 4. Do you rent space to, or otherwise share office space with any dentists who are oral and maxillofacial surgeons, or treatpatients with general anesthetics, intravenous or intramuscular sedatives?
If "Yes," please explain: ____

Yes **No** 5. Do you take a written health history on every patient in your practice? **ATTACH A COPY OF THE HEALTH HISTORY FORM USED IN YOUR PRACTICE.**
If "No," please explain:____

Yes No 6. Do you surgically insert fixtures or other types of implants?
If "Yes," please complete items a-c below:

a. How many cases per year?___________

Yes No b. Have you completed a post-doctoral residency program in a hospital or dental school?
If "Yes," indicate:

Type____ Duration _________________

Year Completed _______Hospital or Dental School_______________________________

Yes No c. Have you completed any surgical training program in the use of implants and fixtures?
If "Yes," indicate:

Year Completed___________ Sponsoring Agency ______________________________

Duration of Training ____

Yes No 7. Do you accept **REFERRALS FROM OTHER DENTISTS** for the treatment of patients exhibiting Temporomandibular Joint Dysfunction (TMD)?
If "Yes," please explain: ____

Yes No 8. Are you licensed or operating as a professional other than a dentist?
If "Yes," please describe:____
____

Yes No 9. Are you on staff, or affiliated in any way with a hospital or clinic?
If "Yes," complete the following:

Institution ____

Days per Week ____

Address _________________________ City __________________State ______ Zip ________

Nature of Duties ____

Yes No 10. Have you ever experienced, or are you currently experiencing alcoholism, narcotic addiction, or mental illness?
If "Yes," please give details: ____

Yes No 11. During the past 5 years have you been under the care of a physician?
If "Yes," describe why treatment was sought, current status and date of last visit: ______
____

Yes 12. Have you ever practiced in any state(s) other than listed in Section I, No. 4?
If "Yes," list states: _____________

Yes No 13. Are you an Oral and Maxillofacial Surgeon?

Yes No 14. Do you treat patients who are rendered unconscious **BY YOU OR OTHERS**, through the administering of anesthetics or analgesics **IN A HOSPITAL OR OFFICE**?

Yes No 15. Do you provide treatment to any patient who has been sedated with the use of any I.V. or I.M. sedatives?

Yes No 16. Do you provide treatment to any patient who has been sedated with the use of general anesthetics?

Yes No 17. Do you provide treatment to any patient who has been sedated with nitrous oxide and oxygen?
Yes No **If "Yes," does your equipment have FAIL-SAFE DEVICES?**

Yes No 18. Do you use any pre-treatment medication (other than local anesthetics)?
If "Yes," describe and indicate drugs used and method of administering:
____

Yes No 19. Do you use Sargenti Paste in performing endodontic procedures?
If "Yes," indicate the number of cases per year: ___________________________________

SECTION V: Dental School Faculty - Premium Credit

Faculty of duly accredited dental schools are afforded premium credits. If you are a faculty member of such an institution complete this section. **PLEASE SUBMIT A COPY OF YOUR CURRENT LETTER OF APPOINTMENT.**

Name of Dental School____Telephone No.(___)______________

On faculty since ____________Position/Department____

Days of the Week:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours per Day:	________	________	________	________	________	________

SECTION VI: REPRESENTATION AND ACKNOWLEDGEMENT (To be completed by all 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

Representation: I represent that the information contained herein is true and that it shall be the basis of the policy of Insurance and deemed incorporated therein, should the company/underwriter evidence its acceptance of this application by issuance of a policy. I further represent that I have not withheld any information which is reasonably likely to influence the judgement of the company/underwriter considering this application (i.e. prior claims, prior difficulties with authorities, prior cancellations or refusals to renew by insurance companies, prior lapses of coverage, etc.). If I have withheld any such information, I understand that my coverage may be voided. I further understand that my failure to disclose any information in my possession regarding possible incidents which may lead to claims will relieve the insurance company of any obligation under Prior Acts coverage.

I hereby authorize the insurance company, its agents and representatives to secure claims information from my current and previous insurance carriers.

CLAIMS-MADE APPLICANTS ONLY: I have requested my policy be written on a "Claims-Made" form and acknowledge that this policy will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" policy will not provide insurance coverage for claims which occurred prior to the Prior Acts date of my policy.

I understand that should my "Claims-Made" policy with this insurance carrier ever be cancelled or non renewed, or I decide to terminate it for any other reason, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy but were not reported to the insurance company before the date of the policy termination, I will be required to purchase additional insurance coverage.

SIGNING THIS FORM DOES NOT BIND THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. NO INSURANCE SHALL BE GRANTED UNLESS ALL QUESTIONS ARE ANSWERED AND THE APPLICATION IS SIGNED AND DATED.

Signature____Date Signed____________________

Agent Signature ____ Date Signed____________________

Agent's License #______________________________________