CID Insurance Programs Inc. DBA CID Insurance Services

REQUESTED COVERAGE – OUTPATIENT CLINIC

☐ **Requesting Professional Liability:**

Requested Retro Date: _____

Professional Liability Limits		Professional Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting General Liability:**

Requested Retro Date: _____ or ☐ Occurrence Based Coverage

General Liability Limits		General Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting Employee Benefits Liability (supplement required):**

Requested Retro Date: _____

Employee Benefits Liability Limits		Employee Benefits Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $1,000	☐ $10,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $2,500	☐ $15,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $5,000	☐ $20,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $7,500	☐ $25,000

☐ **Requesting Non-Owned Auto Liability (supplement required):**

Non-Owned Auto Liability Limits	
☐ $100,000	☐ $500,000
☐ $200,000	☐ $1,000,000
☐ $250,000	☐ Other: _____

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.

CID Insurance Programs Inc. DBA CID Insurance Services

APPLICATION FOR CLINICS (Medical, Dental, Public Health)

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Mailing Address:_____
   STREET CITY COUNTY STATE ZIP

3. Location Address: Check here if same as mailing: ☐

   (1) _____
   STREET CITY COUNTY STATE ZIP

   (2) _____
   STREET CITY COUNTY STATE ZIP

   (3) _____
   STREET CITY COUNTY STATE ZIP

   (4) _____
   STREET CITY COUNTY STATE ZIP

   Attach Additional Pages as Needed

4. Website Address: **www.**_____ 5. Telephone: _____

6. Inspection/Risk Management Contact Name: _____

7. Inspection/Risk Management Contact E-mail: _____

8. Date Established _____ Years under current management _____

9. Applicant is a:

   ☐ Individual
   ☐ Corporation
   ☐ LLC
   ☐ Other:_____
   ☐ Professional Associations
   ☐ Partnership
   ☐ Joint Venture

10. Enterprise is: ☐ For Profit ☐ Not For Profit

11. Is this entity owned by, associated with or controlled by any other entity? Yes ☐ No ☐

If yes, please provide details:

_____

_____

OPERATIONS

12. **Please check the category which best describes your organization**

☐ Health and Wellness Center	Center or clinics established for primarily walk-in patients for basic health and health-related services. Primary care providers predominantly RNs or LPNs, NPs, and physician assistants. Facilities in this category would include free clinics open to the public or those provided for students/faculty of schools, colleges, universities.
☐ Primary Care Clinic	Majority of patient visits are scheduled preventative health services. This category can also include extended hours walk-in clinics where urgent care services are not the primary services provided by your organization. Your regular office hours have been extended to include the addition of walk-in care services. Primary care givers during these hours could include physicians or mid-level providers, although physicians are available during the extended hours.
☐ Urgent Care Center	Urgent care services are the primary activities performed by your organization. Physicians regularly staff your locations with the support of mid-level providers. Services provided are sometimes broader in scope than those typically found in a physician's office. Locations may offer a range of services including physical therapy, occupational therapy, occupational health (Workers Compensation exams), on site x-ray and clinical lab.
☐ Emergi-Center	High level of acuity and may include minor invasive procedures such as those provided in emergency care centers/emergency rooms. Services would also include high level treatment for trauma or severe illness and crisis stabilization. Treatments may require moderate to high levels of anesthesia
☐ Other	Please provide a description of your organization if it does not **readily** reflect one of the above categories. _____ _____

13. Please list all accreditations and association memberships held by the applicant's facility (Joint Commission, AAAHC, etc):

_____

_____

14. Days and Hours of Operation: _____

15. Please state sources and amounts of total revenue:

Source	Last 12 months	Next 12 months
Charitable contributions	$_____	$_____
Government Funding	$_____	$_____
Fee for services	$_____	$_____
Other – specify:	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

16. Please indicate number of patient visits:

	Past 12 Months	Estimated Next 12 Months
Emergency Visits	_____	_____
Urgent Care visits	_____	_____
Health/ Wellness Visits	_____	_____
Other:_____	_____	_____
TOTAL VISITS	_____	_____

17. If your facility offers any of the following services on site please provide the number of tests, prescriptions, or imaging studies respectively performed:

	Past 12 Months	Estimated next 12 Months
X-ray / Imaging	_____	_____
Pharmacy	_____	_____
Laboratory	_____	_____

Are any of these services offered to individuals who are not your facility's primary patient? ☐ YES ☐ NO ☐ N/A

18. Please indicate percentage of patients among the following:

_____ % Urgent Care
_____% Emergency Care
_____% General Practice / Family Practice
_____% Dialysis
_____% Occupational health
_____% Students
_____% Surgical
_____% Other (please describe) _____

_____% Alternative Medicine
_____% Women's Health/ Gynecological
_____% Sleep Studies
_____% Psychiatric
_____% Weight loss
_____% Crisis Stabilization

19. Does the applicant maintain any beds for overnight occupancy? ☐ YES ☐ NO
If yes, please provide total number _____

20. Is anesthesia administered by the applicant, the applicant's employees or independent contractors other than topical or local? ☐ YES ☐ NO **If yes, please provide a detail explanation on page 6.**

21. Does the applicant's employees or independent contractors perform any prenatal care or obstetrical procedures? ☐ YES ☐ NO **If yes, please provide details on page 6.**

22. Does the applicant, employees, or independent contractors use drugs for weight reduction? ☐ YES ☐ NO
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.

23. Does the applicant perform laser hair removal, botox injections or dermal filler injections? ☐ YES ☐ NO **If yes, please complete medical spa supplement.**

24. Does the applicant perform any psychiatric shock therapy? ☐ YES ☐ NO

25. Does the applicant perform any chelation therapy services? ☐ YES ☐ NO

26. Does the applicant administer any methadone treatment? ☐ YES ☐ NO
If yes, provide the number of treatments:
Last 12 Months _____ Next 12 Months _____

27. Does the applicant maintain written documentation of procedures for patient intake and follow-up? ☐ YES ☐ NO

28. Please provide name and location of any hospital or medical facility that the applicant refers in practice?
_____

STAFF

29. Please indicate the number of employed and contracted staff:

	Number Employed?		Number Contracted		Insured	Coverage
	Full Time	Part Time	Full Time	Part Time	Elsewhere?	Desired?
Acupuncturists					☐ YES ☐ NO	☐ YES ☐ NO
Chiropractors*					☐ YES ☐ NO	☐ YES ☐ NO
Dentists*					☐ YES ☐ NO	☐ YES ☐ NO
Inhalation/ Respiratory Therapists					☐ YES ☐ NO	☐ YES ☐ NO
Laboratory Technicians					☐ YES ☐ NO	☐ YES ☐ NO
Licensed Practical Nurses					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Anesthetists					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Midwives*					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Practitioner					☐ YES ☐ NO	☐ YES ☐ NO
Opticians					☐ YES ☐ NO	☐ YES ☐ NO
Optometrists					☐ YES ☐ NO	☐ YES ☐ NO
Paramedics/ EMT's					☐ YES ☐ NO	☐ YES ☐ NO
Perfusionists					☐ YES ☐ NO	☐ YES ☐ NO
Pharmacists					☐ YES ☐ NO	☐ YES ☐ NO
Physician Assistant					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – Major Surgery*					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – Minor surgery*					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – No surgery*					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – OBGYN*					☐ YES ☐ NO	☐ YES ☐ NO
Physiotherapists					☐ YES ☐ NO	☐ YES ☐ NO
Registered Nurses					☐ YES ☐ NO	☐ YES ☐ NO
Social Workers					☐ YES ☐ NO	☐ YES ☐ NO
Speech Therapists					☐ YES ☐ NO	☐ YES ☐ NO
X-ray Technicians					☐ YES ☐ NO	☐ YES ☐ NO
Other: Specify					☐ YES ☐ NO	☐ YES ☐ NO

* Additional applications required if coverage is desired

30. Please provide the name and specialty of the applicant's Medical Director: _____
Does the applicant's Medical Director have direct patient care? ☐ YES ☐ NO
☐ Full Time or ☐ Part Time

31. Are all above individuals licensed in accordance with applicable state and federal regulations? ☐ YES ☐ NO

32. Do you require contracted staff to carry their own professional liability insurance? ☐ YES ☐ NO
If yes, what limits do they carry? _____

33. Do all physicians (employed and contracted) carry their own professional liability coverage? ☐ YES ☐ NO
If yes, what limits do they carry? _____

34. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:
☐ Check of educational background, or residency program, when applicable.
☐ Check of previous employers (☐ In writing ☐ By Telephone)
☐ Criminal background check (☐ STATE ☐ FEDERAL)
☐ Drug / Alcohol / Abuse Screening (circle all that are used)
☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
☐ Require information on any professional liability or work-related claim that has previously been made against any Individual?

35. Does your facility have written job descriptions? ☐ YES ☐ NO

COVERAGE HISTORY AND LOSS HISTORY

36. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Retroactive date

37. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Occurrence or Claims Made

If the current expiring GL policy is claims- made what is the retroactive date? _____

Provide details for all "yes" answers to questions 37-42 on page 6 or attach additional pages as needed

38. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 7 or attach additional pages as needed.** ☐YES ☐NO
39. Has the applicant or any of its employees ever been charged with, or convicted of a crime **<u>other</u>** than minor traffic violations? **Explain on page 7 or attach additional pages as needed.** ☐YES ☐NO
40. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 7 or attach additional pages as needed.** ☐YES ☐NO
41. Has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance? **How Many? _____ (Complete Supplemental Claims form for Each.)** ☐YES ☐NO
42. Is the Applicant or any person 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? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐YES ☐NO
43. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐YES ☐NO

GENERAL LIABILITY - complete only if you are requesting GL coverage

44. Building Description

	Buildings/Wings #1	#2	#3	#4
Type of Construction:	_____	_____	_____	_____
No. of Stories:	_____	_____	_____	_____
Square Footage	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Smoke detectors:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Local/Central station fire alarm:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler System:	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial

45. Do any of the Applicant's locations have any (explain any "yes" answers on page 6):

a. Exposure to flammables, explosive, chemicals? ☐ YES ☐ NO
b. Catastrophe exposure? ☐ YES ☐ NO
c. Exposure to radioactive materials? ☐ YES ☐ NO

46. Has any claim for General Liability **ever** been made against any person(s) or entity(ies) proposed for this insurance? If Yes, complete a supplemental claims form for each. ☐ YES ☐ NO

47. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, answer complete supplemental claims form for each. ☐ YES ☐ NO

SUPPLEMENTAL INFORMATION Use the remainder of this page as needed or to address questions referenced within the application

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policyholder or claiming with regard to a settlement or award payable for 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 insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 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 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 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 NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 and the stated value of the claim for each such violation.

NOTICE TO 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 or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 a 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.

NOTICE TO TENNESSEE 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 include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA 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 include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.
Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent / Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
c. Did you want to settle?
☐ Yes ☐ No

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment:
$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____

CID Insurance Programs Inc. DBA CID Insurance Services

DENTIST AND ORAL SURGEON SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER NOT EARLIER THAN 45 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF COVERAGE.
ATTACH ADDITIONAL SHEETS AS NECESSARY.
ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

GENERAL INFORMATION

1)

Named Insured:	
Professional Designation:	Social Security Number:
US Citizen? Yes ☐ No ☐	Date of Birth:
Immigration status:	Entry date:
Federal DEA License #:	DEA License Status:
Phone Number:	Email Address:
Brokerage/Broker:	Agency/Agent:
Renewal? Yes ☐ No ☐	Policy Number:
Effective Date:	
Website:	

2) Current/Most Recent Professional Liability Carrier Information:

Carrier:					
Limit of Insurance:					
Deductible:		Premium:			
Policy Term Dates:					
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐		Retroactive date:		

3) Current/Most Recent Commercial General Liability Carrier Information:

Carrier:					
Limit of Insurance:					
Deductible:		Premium:			
Policy Term Dates:					
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐		Retroactive date:		

Please attach copies of the following:

a) Currently valued five year loss runs, including claim detail for all losses
b) Copy of your current Professional Liability insurance Declarations Page and Commercial General Liability insurance Declarations Page (claims made policies must reflect the retroactive date and limits for retro continuity)
c) A copy of all marketing materials, brochures, etc. if a website is not available
d) A copy of your business letterhead
e) A copy of all licenses and board certifications held by you
f) A copy of all reporting endorsements previously issued to you

4) Mailing Address: _____

City: _____ State: _____ Zip Code: _____

5) Practice Address: _____

City: _____ State: _____ Zip Code: _____

6) Are you a(n): ☐ Corporation ☐ Individual ☐ Partnership ☐ LLC
☐ Employed Dentist ☐ Contracted Dentist ☐ Other: _____

a. If you are employed or contracted, by whom? _____

7) Your practice is: ☐ Solo Practice ☐ Group Practice ☐ Other: _____

8) What is the entity name of your practice? _____

a. What is your ownership percentage? _____ %

b. How many other dentists practice at this entity? _____

c. Are you seeking coverage for this entity? If yes please attach articles of incorporation. Yes ☐ No ☐

9) Do you practice with any other dentists not included in 8) above? Yes ☐ No ☐

a. If yes, please list their name(s) and practice relationship: _____

_____

10) Please complete the following table for states in which you are licensed to practice:

State	% of Practice	License #	Status
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐

PRACTICE SPECIALTY AND DENTAL EDUCATION INFORMATION

11) Please complete the below table for all locations and dates of practice you have had in the last ten years:

Practice Name	City/State	Specialty	Beginning Date	End Date

12) What is your current practice specialty? _____

a. What percentage of your practice is under this specialty? _____ %

b. What is your current subspecialty: _____

c. What percentage of your practice is under this subspecialty? _____ %

13) Please complete the following table for your education history:

	Institution	Location	Degree/Specialty	Completed?
Dental School				Yes ☐ No ☐
Internship				Yes ☐ No ☐
Residency				Yes ☐ No ☐
Additional Residency				Yes ☐ No ☐
Fellowship				Yes ☐ No ☐

14) Please complete the following regarding your board certification:

a. Are you: ☐ Board Certified ☐ Board Eligible ☐ Board Qualified

b. Name of Board(s): _____

_____

c. Date of Exam: _____

d. If you have been Board Eligible for over five years, but not Board Certified, please explain: _____

_____

_____

15) What date did you begin practicing dentistry? _____

16) How many CE hours have you completed in the past 2 years? _____

17) Are you a member of any dental or professional associations? Yes ☐ No ☐

a. If yes, which one(s)? _____

_____

18) Are you a foreign dental school graduate? Yes ☐ No ☐

a. What date did you begin practicing in the US? _____

DENTAL PRACTICE AND PROCEDURE INFORMATION

19) Please complete the following table for procedures/treatments that you perform. Check and complete all that apply:

Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months	Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months
☐ Bone Grafting	%	%	☐ Cosmetic Dentistry (complete 22) below)	%	%
☐ Cosmetic Procedures – Non-Dental (complete 23) below)	%	%	☐ Endontics – Single Rooted	%	%
☐ Endontics – Multi Rooted	%	%	☐ Endontics – Sargenti Multi Rooted Canal Method	%	%
☐ General Dentistry – Root Canal	%	%	☐ General Dentistry – Oral Surgery	%	%
☐ General Dentistry – Extractions of Impacted Teeth	%	%	☐ General Dentistry – Simple Extractions Only	%	%
☐ Implants - Restoration	%	%	☐ Implants - Placement	%	%

☐ Microneurosurgical Procedures	%	%	☐ Oral Pathology	%	%
☐ Oral Radiology	%	%	☐ Orthodontics	%	%
☐ Orthognathic Procedures	%	%	☐ Pediatric Dentistry	%	%
☐ Periodontics	%	%	☐ Prosthodontics	%	%
☐ Prosthetics - Fixed	%	%	☐ Prosthetics - Removable	%	%
☐ Prosthetics – Sleep Apnea	%	%	☐ Prosthetics - Surgery	%	%
☐ Prosthetics - Therapy	%	%	☐ Surgery – Facial – Elective Cosmetic	%	%
☐ Surgery – Head and Neck	%	%	☐ Surgery – Oral/Maxillofacial	%	%
☐ Surgery – Outside Oral/Maxillofacial Region:_____	%	%	☐ TMJ – Non-Surgical	%	%
☐ TMJ – Surgical	%	%	☐ Uvulopalatoplasty	%	%
☐ Other: _____	%	%	☐ Other: _____	%	%
☐ Other: _____	%	%	☐ Other: _____	%	%
☐ Other: _____	%	%	☐ NONE OF THE ABOVE	INITIAL TO CONFIRM: _____	

** Additional supplemental application required*

20) If you are performing cosmetic dental procedures, please indicate which you're performing. Check all that apply:

☐ Bonding ☐ Enamel Shaping ☐ Full Mouth Restoration
☐ Veneers ☐ Whitening with Lasers ☐ Other Laser Procedure: _____
☐ Other Procedure: _____ ☐ Other Procedure: _____ ☐ Other Procedure: _____

21) If you are performing cosmetic procedures, please indicate which you are performing. Check all that apply:

☐ Botox Injection ☐ Chemical Peels ☐ Chemobrasion
☐ Collagen Injection ☐ Dermabrasion ☐ Face Lift
☐ Laser Skin Resurfacing ☐ Lipodissolve ☐ Liposuction
☐ Microdermabrasion ☐ Reconstructive Surgery ☐ Rhinoplasty
☐ Silicone Injection ☐ Other Laser Procedure: _____ ☐ Other Procedure: _____

a. Where are these performed?
☐ Office ☐ Hospital ☐ Other: _____

22) If you have performed any implant procedures in the last year, please check which and indicate how many. Check all that apply:

☐ Osseointegration only #_____ ☐ Endosteal - Ramus Frame #_____
☐ Endosteal - Other #_____ ☐ Subperiosteal #_____
☐ Transosseus #_____ ☐ Other: _____ #_____

a. Do you perform sinus lifts or other surgical procedure in conjunction with implant procedures? Yes ☐ No ☐

23) What are your average weekly practice hours? _____

24) How many weekly patient encounters do you have on average? _____

25) Approximate gross income from you practice: $_____

26) If you are performing any of the following surgical procedures/treatments, please indicate where they are performed:

Procedure	Location
Acupuncture	☐ Office ☐ Hospital ☐ Other: _____
Adenoidectomy	☐ Office ☐ Hospital ☐ Other: _____
Assist in Surgery	☐ Office ☐ Hospital ☐ Other: _____
Biopsies	☐ Office ☐ Hospital ☐ Other: _____
Blepharoplasty	☐ Office ☐ Hospital ☐ Other: _____
Cheek Implant	☐ Office ☐ Hospital ☐ Other: _____
Chin Surgery	☐ Office ☐ Hospital ☐ Other: _____
Cleft Lip/Palate Surgery	☐ Office ☐ Hospital ☐ Other: _____
Clinical Trials	☐ Office ☐ Hospital ☐ Other: _____
Closed Reduction Fractures	☐ Office ☐ Hospital ☐ Other: _____
Complex Flaps and Grafts	☐ Office ☐ Hospital ☐ Other: _____
Cryosurgery	☐ Office ☐ Hospital ☐ Other: _____
Dental Alveolar Surgery	☐ Office ☐ Hospital ☐ Other: _____
Extractions (Impacted)	☐ Office ☐ Hospital ☐ Other: _____
Extractions (Non-Impacted)	☐ Office ☐ Hospital ☐ Other: _____
Needle Biopsy	☐ Office ☐ Hospital ☐ Other: _____
Nerve Grafts	☐ Office ☐ Hospital ☐ Other: _____
Oral/Maxillofacial Surgery	☐ Office ☐ Hospital ☐ Other: _____
Open Reduction of Fractures	☐ Office ☐ Hospital ☐ Other: _____
Sargenti Root Canal Method	☐ Office ☐ Hospital ☐ Other: _____
Sinus Lift	☐ Office ☐ Hospital ☐ Other: _____
TMJ Surgery	☐ Office ☐ Hospital ☐ Other: _____
Uvulopalatoplasty	☐ Office ☐ Hospital ☐ Other: _____
Other: _____	☐ Office ☐ Hospital ☐ Other: _____
☐ I do not perform any surgical procedures or treatments	Initial to confirm: _____

27) Have you ever used a Vitek Proplast TMJ implant in your practice? Yes ☐ No ☐

a. If yes, have all such implants been replaced? Yes ☐ No ☐

b. Date of last implant: _____

28) Do you use analgesia, sedation, or anesthesia on patients? Yes ☐ No ☐

a. If yes, is application local only? Yes ☐ No ☐

29) If you perform any of the following types of anesthesia, please complete the below table:

	Inhalation Conscious	Oral Conscious	Parenteral Conscious	Parenteral Deep Sedation	General Anesthesia
Percent of patients under 18					
Drug(s) Used					

Office, Surgi-Center, or Hospital Setting					
Administered by:	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________

30) Do you adhere to Harvard Standards for anesthesia administration? Yes ☐ No ☐

31) Do you hold an ALCS certificate? Yes ☐ No ☐

32) Which of the following emergency treatment items do you have available? Check all that apply:

☐ Oral Airway ☐ Ambu bag ☐ Endotracheal tubes/scopes
☐ Oxygen ☐ Emergency Drugs ☐ None Available
☐ Other: ____________ ☐ Other: ____________ ☐ Other: ____________

33) Have there been any changes in your specialty or practice activities in the last ten years? Yes ☐ No ☐
a. If yes, please attach an explanation.

34) Do you anticipate any changes in your specialty or practice activities in the next year? Yes ☐ No ☐
a. If yes, please attach an explanation.

35) Do you perform any procedures not routinely performed by others practicing in your specialty or subspecialty? Yes ☐ No ☐
a. If yes, what procedures? ____________________

36) Are you presently on staff at any hospitals or surgery centers? Yes ☐ No ☐
a. If yes, please complete the below table for these exposures:

Facility Name	City and State	Percent of Work	Type of Privileges
		%	
		%	
		%	

b. If no, please attach protocols for patient admission.

37) Are you currently, or have you ever previously been, a hospital chief of staff or head of any hospital department? Yes ☐ No ☐
a. If yes, when? ____________________
b. What hospital and department? ____________________
c. If this position is not current, why did you exit the position? ____________________
____

38) Do you work in an emergency room, other than to maintain privileges? Yes ☐ No ☐
a. If yes, how many hours per month on average? ____________________

39) What percentage of your work is Locum Tenens? ____________________%
a. Do you work for any Locum Tenens companies as an employee or independent contractor? Yes ☐ No ☐
b. If yes, how many hours each month? ____________________
c. Does the Locum Tenens company provide you with Professional Liability insurance? Yes ☐ No ☐
d. If yes to c., please attach a copy of the COI.

40) Do you read your own x-rays? Yes ☐ No ☐
   a. If yes, approximately how many hours before they are subsequently read by a radiologist? _____

41) Do you read or interpret films, slides, or specimens of patients who reside in states other than your indicated practice states? Yes ☐ No ☐
   a. Which states do you offer these services in? _____
   b. What percentage of your practice are these operations? _____ %

42) Are you employed by the federal, state or local government (full or part time, including active duty military)? Yes ☐ No ☐
   a. If yes, please attach details.

43) Do you wire jaws closed for the purposes of weight loss? Yes ☐ No ☐
   a. If yes, approximately how many annually? _____

44) Do you treat patients in a nursing home, correctional facility, or similar care facility? Yes ☐ No ☐
   a. If yes, what percentage of your practice are these operations? _____ %
   b. Please list the facilities: _____

45) Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? Yes ☐ No ☐
   a. If yes, please attach a detailed list of the procedures or drugs and a description of protocols and procedures.

46) Do you endorse any products or participate in any activity which offers professional advice to the public, including but not limited to newspaper columns any broadcasts? Yes ☐ No ☐
   a. If yes, please attach an explanation and samples of past publishing.

47) Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering dental services? Yes ☐ No ☐
   a. Do you prescribe drugs or provide diagnosis via the internet or telehealth? Yes ☐ No ☐
   b. If yes to 40) or a., are these services limited to current patients whom you have previously had at least one in-office visit? Yes ☐ No ☐
   c. What state(s) are you offering these services?
   d. What percentage of you practice are these operations? _____ %

STAFF INFORMATION

48) Please complete the following for your staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
Dental Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Dental Technician					Yes ☐ No ☐	Yes ☐ No ☐
Hygienists					Yes ☐ No ☐	Yes ☐ No ☐
Physician*					Yes ☐ No ☐	Yes ☐ No ☐
Physician Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Surgeon Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Lab Technician					Yes ☐ No ☐	Yes ☐ No ☐

Pharmacist					Yes ☐ No ☐	Yes ☐ No ☐
RN, LPN					Yes ☐ No ☐	Yes ☐ No ☐
CRNA					Yes ☐ No ☐	Yes ☐ No ☐
X-Ray Technician					Yes ☐ No ☐	Yes ☐ No ☐
Other: _____					Yes ☐ No ☐	Yes ☐ No ☐

** Requires separate application*

49) Are all of the individuals included in the table above licensed in accordance with applicable State and Federal regulations? Yes ☐ No ☐

50) Do you employ, contract with or supervise any dentists? Yes ☐ No ☐

a. If yes, please list their names and attach certificates of insurance for each: _____

_____

_____

51) Do you share office space or have an expense sharing arrangement with any other dentist other than those named above? If yes, please attach an explanation. Yes ☐ No ☐

52) Which of the following procedures do you use for hiring/screening professionals and paraprofessionals who provide patient care services in your operations other than surgeons and anesthesia providers? Check all that apply:

☐ Check of educational background
☐ Check of residency program
☐ Check of previous employers – In writing
☐ Check of previous employers – By telephone
☐ Criminal background check – State
☐ Criminal background check – Federal
☐ Driver's license verification
☐ MVR Check
☐ Drug screening
☐ Alcohol screening
☐ Abuse screening
☐ Reference verification
☐ Verification of license validity, suspensions, revocations, citations, or pending disciplinary actions
☐ Verification of any pending disciplinary actions by current or previous employers
☐ Verification of Professional Liability or other workplace related claims history against the applicant
☐ Other: _____

COVERAGE AND LOSS HISTORY

53) Has any licensing authority or professional association taken any action against you or any of your employees? **If yes, please attach an explanation and copies of all citations.** Yes ☐ No ☐

54) Have you or any of your employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If yes, please attach an explanation.** Yes ☐ No ☐

55) Has your board certification or membership in any dental society or association been refused, suspended, revoked, or voluntarily surrendered? **If yes, please attach an explanation.** Yes ☐ No ☐

56) Have your hospital privileges been suspended, restricted, denied, placed in probation status, or revoked? **If yes, please attach an explanation.** Yes ☐ No ☐

57) Have you or any of your employees ever been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

58) Have you or any of your employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

59) During the past five years, has any insurer ever canceled or non-renewed similar insurance to any applicant or has your insurance been canceled for nonpayment of premium by any insurance or finance company. **If Yes, please attach an explanation.** Yes ☐ No ☐

60) Have you ever practiced without Professional Liability insurance in place? Yes ☐ No ☐

61) Do you have Professional Liability insurance in place for work you do elsewhere? Yes ☐ No ☐
If yes, please attach a copy of the policy Declarations page(s).

62) Has any claim or suit for medical malpractice or professional liability ever been filed, or any claim otherwise been made against you or any other person proposed for this insurance, including any partnership or joint venture of which you have been a member or your company's predecessors in business? Yes ☐ No ☐
   a. **If yes, please complete the Kinsale Health Care Claim Supplemental.**
   b. How many malpractice or professional liability claims have you had? _____
   c. Have these claims all been reported to your current or a prior insurer? Yes ☐ No ☐

63) Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

64) If your Professional Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

65) If your Commercial General Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policyholder or claiming with regard to a settlement or award payable for 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 insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 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 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 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 NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 and the stated value of the claim for each such violation.

NOTICE TO 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 or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 a 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.

NOTICE TO TENNESSEE 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 include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA 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 include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____