CNA HEALTHCARE
PROFESSIONAL LIABILITY INSURANCE FOR DENTISTS
CLAIMS-MADE COVERAGE

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant.
3. A copy of your letterhead must be included. Also, please include a copy of all of your "Yellow Pages" advertising, if any.

I agree that any coverage issued will be contingent upon the truth of the following information and any material misrepresentation could result in the voiding of coverage or cancellation of my policy.

LIMITS REQUESTED:		☐ New Policy Requested Effective Date: ___/___/___
❑ $100,000/$300,000	❑ $250,000/$500,000	
❑ $500,000/$750,000	❑ $750,000/$1,000,000	☐ Renewal of Policy Number_____
❑ $1,000,000/$3,000,000	❑ Other: $_____/$_____ **(STATE EXCEPTIONS MAY APPLY)**	

PERSONAL/PROFESSIONAL DATA

1. Name: (First/Middle Initial/Last/Designation) ☐ DDS ☐ DMD ☐ MD ☐ BDS _____

2. Social Security Number: _____

3. Date of Birth: _____

4. Mailing Address: _____
Street City State Zip Code

5. Telephone Number: (_____)_____

6. Fax Number: (_____)_____

7. E-mail Address: _____

8. Years in Practice: _____

9. Dental School Attended: _____

10. Month/Year of Graduation: _____

11. Under which business structure do you practice?

❑ Sole Proprietor ❑ Limited Liability Company ❑ Limited Liability Partnership ❑ Incorporated ❑ Partnership

❑ Employee Dentist …….. Name of Employer/Facility:_____

❑ Independent Contractor……. Name of Employer/Facility: _____

❑ Faculty ……..... Name of Employer/Facility: _____

If you own your practice, please complete the following:

A. Name of your legal entity (if any) _____
B. Is the sole function / purpose of this entity for the practice of dentistry? .....❑ Yes ❑ No
If no, please provide details (attach a separate sheet if necessary) _____
_____
C. Do you desire **Shared** limits of liability to apply to your legal entity? .....❑ Yes ❑ No

D. Excluding yourself, name all officers or partners of your legal entity:_____
_____
_____

E. Please provide the number of the following who work for you:
❑**Employee Dentist** (other than yourself and / or partners/corporate officers) *_____
❑ **Independent contractor dentists *** _____
❑ **Other dentists** sharing facilities with you who are **not** covered under this policy) * _____
* **NOTE: For any of the ABOVE 3 selections**, be sure to attach a separate application or proof of professional liability coverage for each
❑ **All other employees** (hygienists, assistants, technicians, clerical, etc.) _____

12. Practice Addresses and Percentage of Practice at Each Address (**Total of Percentages Must Equal 100%**) :

Primary

1) _____

Street City County State Zip Code %

Secondary

2) _____

Street City County State Zip Code %

Secondary

3) _____

Street City County State Zip Code %

13. Are you currently licensed to practice dentistry?..... ❑Yes ❑No

State(s):_____

Dental License #(s):_____

DEA License #(s): _____

14. Indicate your Practice Specialty

❑ General Dentistry ❑ Orthodontics ❑ Public Health

❑ Endodontics ❑ Pediatric Dentistry ❑ Full-time Faculty-Non-Intramural

❑ Oral/Maxillofacial Surgery * ❑ Periodontics ❑ Anesthesiology(Dental)-Conscious Sedation *

❑ Oral Pathology ❑ Prosthodontics ❑ Anesthesiology(Dental)-General Anesthesia *

* Supplemental Questionnaire must be completed

15. What is the percentage of your patient makeup in the following categories. Please indicate "0" or "N/A' if none.

Direct pay by patient and/or fee for service _____% Managed Care HMO/PPO/IPA _____%

Medicare/Medicaid patients***** _____% Other: _____% Describe: _____

***If you treat Medicare/Medicaid patients, please complete the following:**

Number of adult **Medicare/Medicaid patients** seen per year: _____

Number of children **Medicare/Medicaid patients** seen per year: _____

16. Which of the following procedures are performed by you:

❑ Irreversible TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

❑ Implant Surgery ❑ Implant Restoration ❑ Molar Endodontics on Permanent Teeth

❑ Extraction of Impacted teeth ❑ "Sargenti", paste fill, formaldehyde based or similar endodontic technique EXCLUDING formocresol primary tooth pulpotomies

❑ Sleep Apnea Therapy* ❑ Weight Loss Therapy*

*If Sleep Apnea or Weight Loss Therapy performed, please indicate the following and provide detailed explanation of treatment: (check all that apply)

Sleep Apnea: ❑ I fabricate snore guard ❑I treat only after physician referral ❑ I treat without physician referral

Weight Loss: ❑ I treat only after referral from physician ❑ I treat without physician referral

❑ Cosmetic procedures (including but not limited to Botox, Restalyne,Colagen Injections, dermabrasions, etc.)**

If Yes, please provide a detailed explanation including services performed by you and/or someone under your supervision/direction

17. Do you operate a dental laboratory? ……..……..❑ Yes ❑ No

If "**Yes**" do you accept referrals for other than your patients? ……..…❑ Yes ❑ No

If " **Yes**" is there a separate business entity / corporation for this purpose? ……❑ Yes ❑ No

18. Do you provide radiology services for other than your patients or on a referral basis? ……❑ Yes ❑ No

"if **Yes**" is there a separate business entity / corporation for this purpose? ……❑ Yes ❑ No

19. Are you in compliance with OSHA and CDC Standards for infection control? ……..❑ Yes ❑ No

20. Do you use written consent forms prior to performing dental procedures?.....…….. ❑ Yes ❑ No

21. Do you obtain oral informed consent prior to performing dental procedures?.....……..❑ Yes ❑ No

If Yes, do you document your records:

❑ Always ❑ Often ❑ Sometimes ❑ Rarely ❑ Never

Please be sure to read and answer all parts very carefully. For purposes of these questions, the following definitions of **Anxiety Reduction, Conscious Sedation** and **General Anesthesia/Deep Sedation** are provided:

- **Anxiety Reduction** is defined as "the use of nitrous oxide/oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety."
- **Conscious sedation** is defined as: "A 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 pharmacologic or non-pharmacologic method, or a combination thereof."
- **General Anesthesia and Deep Sedation** are defined as: "A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof."

22. A. Is your practice limited to the use of local anesthesia, oral medication and/or nitrous oxide?.....❑ Yes ❑ No
B. Are you treating patients who are under IV conscious sedation? ……..……..❑ Yes ❑ No
C. Are you treating patients who are under general anesthesia / deep sedation?..……..... .....❑ Yes ❑ No
If **"Yes",** where are the procedures performed? ……..❑ In your office ❑ In a hospital or surgical center
If **"In Your Office",** who administers the anesthesia? ……..❑ You ❑ Another Dentist, Anesthesiologist or CRNA
(Please provide proof of Professional Liability Coverage if administered by someone other than you)

23. A. Have you ever had a change in the status of your hospital privileges?.....❑ Yes ❑ No
If "**Yes**", provide details on a separate sheet of paper.
B. Has any governmental agency, including a state licensing board, ever suspended, revoked, or taken any other action against either your narcotics license or license to practice dentistry?…….....❑ Yes ❑ No
If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.
C. Have you been convicted of any criminal charges?.....❑ Yes ❑ No
If "**Yes**", provide details from investigating agency.
D. Have you ever been treated, or are you currently being treated for alcoholism, drug addiction, mental illness or physical impairment? .....❑ Yes ❑ No
If "**Yes**", provide a letter from treating physician with complete details.

INSURANCE HISTORY

24. Are you now, or have you ever, practiced without professional liability insurance?…….....❑ Yes ❑ No
If "**Yes**", provide dates and reason:
_____

25. Have you ever had any professional liability insurance refused, cancelled or non-renewed?.....❑ Yes ❑ No
If "**Yes**", provide dates and reason:
_____

26. Has any claim or suit for alleged malpractice ever been brought against you?…….....❑ Yes ❑ No
If "**Yes**", please complete Supplemental Claim form.

27. Are you currently aware of any situation that could lead to a malpractice suit against you?.....❑ Yes ❑ No
If "**Yes**", please complete Supplemental Claim form.

28. List prior carrier(s) for the past five (5) years. If none, state "None."

Insurer	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability
1.				
2.				
3.				
4.				
5.				

29. Are you applying for prior acts coverage from CNA?…….....❑ Yes ❑ No
If "**Yes**", please attach a copy of your last declaration page (face sheet).

30. Prior Acts date (Retroactive date) used by your previous carrier_____

31. Was an extended reporting endorsement (tail) purchased form your previous carrier?….....❑ Yes ❑ No

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. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage 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 reasons, 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 able to purchase additional insurance coverage.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (For District of Columbia residents only: 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.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: 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.) (For Maine residents only: 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 a denial of insurance benefits.) (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Oklahoma residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (For Pennsylvania residents only: 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 such person to criminal and civil penalties.) (For Puerto Rico residents only: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousands dollars ($5,000) nor more than ten thousands dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Oregon and Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington residents only: 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.)

REMINDER:

- ❑ **Copy of letter head or yellow page advertisement**
- ❑ **Formal up to date loss runs from all prior companies for the past 5 years**
- ❑ **Claim supplemental form must be completed for each claim, incident and/or suit you have been involved in**
- ❑ **Copy of prior carrier dec page – if applying for prior acts coverage**
- ❑ **"Yes" responses to certain questions require attachment of additional documents, are these attached?**

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED

_____

Signature in full: Date

Coverage is underwritten by Columbia Casualty Company, one of the CNA property/casualty insurance companies. CNA is a service mark registered with the US Patent and Trademark Office.