



# The Professional Protector Plan®

## Professional & General Liability Insurance for Dentists

Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A. Application must be signed and dated by applicant.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued.

Requested Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_       New Policy       Rewrite of Policy Number: \_\_\_\_\_

**PLEASE TELL US ABOUT YOURSELF**

1. Full Name: \_\_\_\_\_  DDS  DMD  MD  BDS  MS

2. Mailing Address: \_\_\_\_\_  
City / State / Zip: \_\_\_\_\_

3. E-mail Address: \_\_\_\_\_ 4. Website: \_\_\_\_\_

5. Would you like the PPP's quarterly Risk Management Newsletter sent via email?  Yes  No

6. Telephone Number: \_\_\_\_\_ 7. Fax Number: \_\_\_\_\_

8. All Dental Schools Attended: \_\_\_\_\_ 9. Month / Year of Graduation: \_\_\_\_\_

10. Did you complete a residency?.....  Yes  No  
If "Yes", Specialty: \_\_\_\_\_ Month / Year of Completion: \_\_\_\_\_

11. Are you entering practice for the first time?.....  Yes  No

12. Have you ever practiced dentistry outside of the United States and / or its territories?.....  Yes  No  
If "Yes", please explain: \_\_\_\_\_

13. Date of Birth: \_\_\_\_\_ 14. Years in Practice: \_\_\_\_\_

15. How many hours per week do you practice (include administrative duties, record keeping, lab work, patient visitation and consultation)? \_\_\_\_\_ \*\*  
\*\*If 20 hours or less, please complete a Part-time Supplement provided by your agent.

16. Under which business structure do you practice?  
 Sole Proprietor     Limited Liability Company     Limited Liability Partnership     Incorporated     Partnership  
 Employee Dentist     Independent Contractor     Faculty (**Occurrence** coverage only)     Volunteer (**Occurrence** coverage only)

If applicable, please list name of Employer / Facility: \_\_\_\_\_

If you volunteer, please describe volunteer services provided: \_\_\_\_\_

If you volunteer, will you receive remuneration for your volunteer services?  Yes  No

17. Practice addresses and percentage of practice at each address (total of percentages must equal 100%):

<b>A. Primary:</b>	Street	City	County	State	Zip Code	%
<b>B.</b>	Street	City	County	State	Zip Code	%
<b>C.</b>	Street	City	County	State	Zip Code	%

18. Indicate your Practice Specialty (please check all that apply):

General Dentistry     Dental Radiologist     Periodontics     Oral / Maxillofacial Surgery     Dental Anesthesiologist  
 Endodontics     Oral Radiology     Prosthodontics     Pediatric Dentistry     Full-time Faculty-Non-Intramural

Orthodontics     Public Health     Oral Pathology     Other - describe: \_\_\_\_\_

**PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY COVERAGE NEEDS**

**19. Select the Professional Liability coverage type and limits desired. All limits may not be available in all states (select either Claims-Made or Occurrence):**  
PLEASE CONTACT YOUR AGENT IF HAVE ANY QUESTIONS REGARDING THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE  
AS WELL AS FOR DETAILED INFORMATION REGARDING AN EXTENDED REPORTING PERIOD AS IT RELATES TO CLAIMS-MADE COVERAGE.

**Claims-Made Coverage\*\***

- \$1,000,000 / \$3,000,000     \$2,000,000 / \$3,000,000     \$2,000,000 / \$4,000,000     \$2,000,000 / \$6,000,000     \$3,000,000 / \$3,000,000  
 \$3,000,000 / \$6,000,000     \$4,000,000 / \$4,000,000     \$5,000,000 / \$5,000,000     \$5,000,000 / \$6,000,000     \$5,000,000 / \$8,000,000  
 Other \_\_\_\_\_

(STATE EXCEPTIONS MAY APPLY)

\*\*THIS IS AN APPLICATION FOR CLAIMS-MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

**Occurrence Coverage**

- \$1,000,000 / \$3,000,000     \$2,000,000 / \$2,000,000     \$2,000,000 / \$6,000,000     Other \_\_\_\_\_

(STATE EXCEPTIONS MAY APPLY)

**20. If Claims-Made Coverage is desired, please complete the following:**

**A. Are you applying for prior acts coverage from AAIC?** .....  Yes  No

**B. Retroactive Date / Prior Acts Date on your current Claims-Made policy\*\*:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*If prior acts is desired, please attach a copy of your last declaration page (face sheet)

**C. Was an Extended Reporting Endorsement (tail) purchased from your previous carrier?** .....  Yes  No

**PLEASE TELL US ABOUT YOUR GENERAL LIABILITY NEEDS**

**21. Do you desire shared or separate limits of liability to apply to each location (limits will be equal to your professional liability limits):**

- Shared (Limits are Shared with each location at no additional cost )     Separate (each location has its own set of limits and an additional charge applies)

**22. Have you had any general liability losses in the past 3 years?** (If "Yes", please provide a summary of the loss and claim amount) .....  Yes  No

**23. Do you desire to increase your limit of liability for ERISA Fiduciary Liability Coverage / Employee Benefits Liability above the included \$25,000?**  Yes  No

Coverage is recommended if you sponsor an Employee Benefit Plan. This is NOT the bond for your pension plan. Coverage is written on a Claims-Made basis.

If "Yes", check the desired limit of liability:     \$100,000     \$250,000     \$500,000     \$750,000     \$1,000,000

**24. If you are a TENANT, would you like to increase the standard \$500,000 Fire / Water Legal Liability Limit?** .....  Yes  No

If "Yes", check the desired limit of liability:     \$750,000     \$1,000,000

**25. If you have an equipment lease, building lease, rental agreement, etc. that requires you to name an entity as an additional insured for general liability purposes, please provide the name and address of the entity as it appears in your contract/agreement:**

**PLEASE TELL US ABOUT YOUR OTHER LIABILITY NEEDS**

**26. Standard Employment Practices Liability Defense Coverage Only; limits: \$25,000 Each Claim, \$25,000 Annual Aggregate (coverage is automatically provided unless a STATE EXCEPTION APPLIES).**

Do you wish to amend the standard coverage type from Defense Only to Indemnity and Defense (an additional charge will apply)? .....  Yes  No

If "Yes", please complete the **Employment Practices Liability Indemnity Supplemental Application** provided by your agent.

**27. Standard Cyber Liability Coverage (coverage and limits outlined below are automatically provided at no charge unless a STATE EXCEPTION APPLIES):**

Coverage	Limit Per Occurrence	Aggregate Limit	Total Aggregate Limit	Deductible
Network Extortion	\$5,000	\$50,000	\$150,000	\$1,000 deductible applies to all coverages except Privacy Event Expense.
First Party Loss	\$100,000	\$100,000		
Privacy Event Expense	\$5,000	\$5,000		
Regulatory Investigations	\$50,000	\$100,000		
Privacy Regulatory Proceedings, Network Security and Privacy Injury	\$50,000	\$150,000		

Do you wish to increase the Cyber Liability aggregate limit to \$1,000,000 (an additional charge will apply)? .....  Yes  No

If "Yes", please complete the **Supplemental Application for Information Risk Coverage** provided by your agent.

**PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE**

**28. Which of the following procedures are performed by you?**

- Sleep Apnea Therapy or  Fabrication of Snore Guards Only

If **Sleep Apnea Therapy** is more than snore guards, please indicate the following:

I treat only after referral from physician  Yes  No

I treat without physician referral  Yes  No If **"Yes"**, please provide a written explanation.

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Implant Placement/Uncovering/Surgery       | <b>Informed Consent Type</b>   | <input type="checkbox"/> CE <input type="checkbox"/> Dental School <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Partially Impacted Third Molar Extractions | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> Both | <input type="checkbox"/> CE <input type="checkbox"/> Dental School <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Fully Impacted Third Molar Extractions     | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> Both | <input type="checkbox"/> CE <input type="checkbox"/> Dental School <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Molar Endodontics on Permanent Teeth       | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> Both | <input type="checkbox"/> CE <input type="checkbox"/> Dental School <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Mini-Implants                              | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> Both | <input type="checkbox"/> CE <input type="checkbox"/> Dental School <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> Conscious Sedation                         | <input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> Both | <input type="checkbox"/> CE <input type="checkbox"/> Dental School <input type="checkbox"/> Post Grad <input type="checkbox"/> None |
| <input type="checkbox"/> <b>None of these</b>                       |  |   |

**A. Have you discontinued any procedures listed above in the last five years?**

Yes  No

Which procedures? \_\_\_\_\_

**29. Do you or someone under your supervision/direction perform elective cosmetic dermal procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)?.....**

Yes  No

If **"Yes"**, please provide an explanation on a separate sheet of paper.

**30. Are you treating patients who are under general anesthesia / deep sedation** (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)?

Yes  No

If **"Yes"**, where is the treatment provided?

Your office

Hospital or licensed / regulated surgical center

If administered in **your office**, who administers the anesthesia?

Yourself

Another Dentist, Anesthesiologist, or CRNA \*\*

\*\* Please provide proof of current Professional Liability coverage

**PLEASE TELL US ABOUT YOUR PARTICIPATION**

**31. Are you a member of your state dental association or society? .....**

Yes  No

If **"Yes"**, provide name of association / society: \_\_\_\_\_

**32. Have you taken one of the following risk management seminars in the last 3 years? .....**

Yes  No

If **"Yes"**, please indicate which one and provide evidence of attendance:

PPP (Evidence not required if you are a PPP insured) Date of Attendance: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

AAOMS / OMSNIC  AAO  NYSDA / DSSNY  Henry Spenadel  CNA

**PLEASE TELL US ABOUT YOUR LICENSE HISTORY**

**33. List all states where you hold, or have held, a Dental License even if the license is not currently active (attach a separate sheet if needed):**

State	License Number	Status of License (e.g., active, inactive, pending, etc.)
_____	_____	_____
_____	_____	_____

**34. A. Has any professional conduct or fee complaint ever been filed against you with any licensing or regulatory authority? (State licensing board; DEA; OSHA; EEOC; peer review committee; etc.) .....**

Yes  No

If **"Yes"**, provide a copy of the board transcript or other documentation, including resolution and dates.

**B. Have you, your legal entity, or any of your employees ever had any allegations, convictions, or related fines for Medicaid Fraud?**

Yes  No

**C. Has any governmental agency, including a state licensing board, investigated you or taken action against either your dental and/or narcotics license, including suspension, revocation, probation, restriction, denial, or other sanction? .....**

Yes  No

If **"Yes"**, provide a copy of the board transcript or other documentation, including resolution.

**D. Have you been charged with or convicted of any criminal charges (including a DUI, OWI, etc., not including minor traffic violations)?**

Yes  No

If **"Yes"**, please provide details from investigating agency.

E. Have you ever had hospital or ambulatory surgical facility privileges involuntarily revoked, suspended or otherwise terminated?  Yes  No

If "Yes", please provide details on additional sheet of paper.

F. Have you ever been or are you currently being treated for (if "Yes" to any, please provide a physician's statement):

- Alcoholism.....  Yes  No
- Drug Addiction.....  Yes  No
- Mental Illness.....  Yes  No
- Physical Impairment.....  Yes  No

**PLEASE TELL US ABOUT YOUR PROFESSIONAL LIABILITY CLAIMS HISTORY**

35. A. Has any claim or suit for alleged malpractice ever been brought against you? .....  Yes  No

If "Yes", please complete a Claim Supplement.

B. Are you currently aware of any situation that could lead to a malpractice suit against you? .....  Yes  No

If "Yes", have you reported the situation to your current insurer? .....  Yes  No

If "Yes", please complete a Claim Supplement.

**PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES**

36. Do you operate a dental laboratory? .....  Yes  No

If "Yes", do you accept referrals of patients from other dentists? .....  Yes  No

If "Yes", is there a separate business entity / corporation for this purpose? .....  Yes  No

37. Do you provide radiology services to patients of other dentists? .....  Yes  No

If "Yes", is there a separate business entity / corporation for this purpose? .....  Yes  No

**PLEASE TELL US ABOUT YOUR PRACTICE**

38. A. Name of your legal entity (if any): \_\_\_\_\_

Please list any associated "dba" or fictitious entity name: \_\_\_\_\_

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. If you have a legal entity, do you desire shared or separate limits of liability to apply to your legal entity?

- Shared (limits are shared with you at no cost) **\*\*Shared limits not allowed in CT**
- Separate (entity has its own set of limits and an additional charge applies) **\*\*Separate limits not allowed in IN**

D. Excluding yourself, name all officers or partners of your legal entity \*\*: \_\_\_\_\_

39. If you own your own practice, please provide the number of the following who work for or with you (If none, please write "none" or "0"):

- a. Employee dentists (other than yourself and/or partners/corporate officers) \*\* \_\_\_\_\_
- b. Independent contractor dentists \*\* \_\_\_\_\_
- c. All other employees (hygienists, assistants, technicians, clerical, etc.) \_\_\_\_\_

**\*\* NOTE:** For all employee dentists, independent contractor dentists, and/or other officers or partners of your legal entity, a separate application OR proof of current Professional Liability coverage must be attached for each.

40. Not including practice partners, employees and independent contracted dentists as indicated above, are you in a space-sharing arrangement or agreement with another Dentist, Oral Surgeon, or other Healthcare Provider?  Yes  No

If "Yes", please provide the following:

A. Name(s) and specialty of those with whom you are space-sharing:

Name	Specialty
_____	_____
_____	_____

B. Please attach proof of current Professional Liability insurance for each individual listed in section A. above.

C. Are patient charts for all space-sharing individuals kept in or retrieved from the same area?  Yes  No

41. Do you now, OR have you within the past 5 years, provided professional services in a setting other than your office? (i.e., spa; residence; school; jail; prison; correctional facility; detention center; halfway house or similar type of facility for adults and/or juveniles; etc.).....  Yes  No  
If "Yes", provide a summary of activities and total number of hours per month: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

42. Does your practice include mobile dentistry?  Yes  No  
If "Yes", please answer the following questions:  
A. Do you have a separate business entity / corporation set up for this purpose?  Yes  No  
If "Yes", business entity / corporation name: \_\_\_\_\_  
B. Will dentists other than yourself be providing professional services on behalf of the mobile dentistry service?  Yes  No  
If "Yes", number of dentists: \_\_\_\_\_  
C. What type of patients will you be seeing (e.g., nursing home patients, ACLF patients, school children etc.)? \_\_\_\_\_  
\_\_\_\_\_  
D. If further treatment is required, is a protocol in place to instruct the patient, or Guardian thereof, to seek follow up care?  Yes  No  
E. Please provide additional comments to help us better understand your mobile dentistry practice: \_\_\_\_\_  
\_\_\_\_\_  
43. Do you practice Holistic dental services?  Yes  No  
What percentage of your practice is Holistic? \_\_\_\_\_ If "Yes", please explain: \_\_\_\_\_

**PLEASE TELL US ABOUT YOUR INSURANCE HISTORY**

44. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

Name of Insurance Carrier	Effective Date	Expiration Date	Coverage Type	Limits of Liability
_____	_____	_____	<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence	_____
_____	_____	_____	<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence	_____
_____	_____	_____	<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence	_____

Please explain any gaps in your insurance history: \_\_\_\_\_  
\_\_\_\_\_

45. Will you be providing dental services for which coverage is provided by another Professional Liability policy?  Yes  No  
If "Yes", please explain: \_\_\_\_\_  
\_\_\_\_\_

46. Are you now practicing, or have you ever practiced, without Professional Liability insurance?  Yes  No  
If "Yes", please explain: \_\_\_\_\_  
\_\_\_\_\_

47. Have you ever had any Professional Liability insurance refused, canceled, or non-renewed?  Yes  No  
**THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS**  
If "Yes", please explain: \_\_\_\_\_

**AUTHORIZATION**

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize AAIC to release the information on this application and associated underwriting information.

**FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

**NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON:** Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes 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 and denial of insurance benefits.

**REMINDER TO INCLUDE:**

- If no up to date website has been provided, please provide a copy of letterhead or business card (N/A if you are an Independent Contractor or Employee Dentist)
- Part time supplement – if requesting part time credit
- Employment Practices Liability Indemnity (EPLI) Supplemental Application – if requesting EPLI coverage (*Defense only coverage is automatically included at a \$25,000 sublimit*)
- Evidence of Risk Management attendance – if requesting RM credit
- "Yes" responses to certain questions require attachment of additional documents/information; is this attached?
- Copy of prior carrier declarations page (if applicable)
- Claim Supplement (if applicable)

ADDITIONAL INFORMATION MAY BE REQUESTED AND COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

\_\_\_\_\_  
Signature in full Date

\_\_\_\_\_  
Agent's Signature Date

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

**AGENCY INFORMATION**

<b>RETURN TO:</b>			
State Administrator Name: _____			
Address: _____			
City: _____	State: _____	Zip Code: _____	
Phone #: _____	Agent's License Number: _____		

The Professional Protector Plan is a registered trademark of B & B Protector Plans, Inc.. Coverage is underwritten by AAIC.