Connecticut Medical Insurance Company

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Application for Dentists Professional Liability Insurance - Claims Made (Please type or print in ink)

A. PERSONAL INFORMATION

1. ______________________________
Applicant Name (First, Middle, Last, Professional Designation)

2. ______________________________
Business Mailing Address (Street)
____
(City, State, Zip)

3. ______________________________
Home Address (Street)
____
(City, State, Zip)

4. Office Manager Name ______________________________

5. Office Telephone No. ____________ 6. Fax No. ____________ 7. Home Telephone No. ____________

8. Date of Birth ____/____/____ 9. Social Security No. ____-____-____ 10. Sex M ☐ F ☐

11. Names of business(es) which you own or for whom you work - include names under which you are doing business (DBA)

a. ______________________________
(Name) (Location)

b. ______________________________
(Name) (Location)

12. Attach a copy of all business letterhead(s).

B. CURRENT PRACTICE INFORMATION

1. Connecticut Dental License No. ____________ Expiration Date ____/____/____

2. DEA License No. ____________ 3. Connecticut Controlled Substance No. ____________

4. Business Organization (Check each of the following that applies to your practice)

a. ☐ Solo Unincorporated or Independent Contractor
b. ☐ Sole Shareholder Corporation
c. ☐ Employee of a group or individual
d. ☐ Partner
e. ☐ Professional Corporate Shareholder
f. ☐ Other (describe) ____________

5. Name of corporation, solo corporation, partnership, DBA or employer, if applicable.
____

6. Is coverage for your corporation or partnership desired? ☐ Yes ☐ No - If Yes, complete Corporation/Partnership Application

7. Specialty (check the box that applies to your practice)

☐ General Dentistry	☐ Orthodontics	☐ Oral Pathology
☐ Dual Specialty	☐ Pediatric Dentistry	☐ Anesthesiology (Dental Conscious Sedation)
☐ Endodontics	☐ Periodontics	☐ Anesthesiology (Dental General Sedation)
☐ Public Health	☐ Prosthodontics	☐ Other (specify) ______________________

8. Do you practice out-of-state? ☐ Yes ☐ No

   If Yes, where? ______________________________

   a. How many hours per week do you practice out-of-state? __________

   b. How may patients per week do you see out-of-state? __________

   c. What percentage of your total practice is out-of-state? __________%

9. Do you have a position for which no coverage is required under the CMIC policy or for which you are already otherwise insured?

   ☐ Yes ☐ No - If Yes, provide the name of the hospital or institution that provides the coverage and initial employment date.

   ____
   Name Initial Employment Date

10. Please list below all hospitals where you hold or are applying for privileges and entities to which you need Certificates of Insurance sent.

Hospital/Entity	Send Cert. Of Insurance	Hospital/Entity	Send Cert. of Insurance
__________	☐ Yes	__________	☐ Yes
__________	☐ Yes	__________	☐ Yes

11. How many patients do you treat per week in your office? __________ In the hospital? __________

12. Please check the box next to the organization of which you are a member.

   ☐ Connecticut Dental Association ☐ American Dental Association

   ☐ American Association of Oral and Maxillofacial Surgeons ☐ Other __________

13. List any changes you have made in your practice within the past five years (i.e. new procedures, part-time) __________

   ____

14. Does your office have all oxygen, drugs and appropriate equipment to properly manage emergencies that may occur as a result of procedures or tests performed in your office. ☐ Yes ☐ No

   a. Are you currently certified in
      ☐ Basic Life Support for the Professional Rescuer
      ☐ Advanced Life Support

   b. Is your office staff trained in
      ☐ Basic Life Support for the Professional Rescuer
      ☐ Advanced Life Support

C. PERSONNEL INFORMATION

1. If you own your own practice:

# of full-time _____/ part-time _____ Employee Dentists
# of full-time _____/ part-time _____ Independent Contractor Dentist(s)
Attach proof of professional liability insurance for the Independent Contractor Dentist(s)
# of full-time _____/ part-time _____ Non-Dentist employees
# of full-time _____/ part-time _____ Dental Hygienists

# of full-time _____/ part-time _____ **Total**

D. EDUCATION

Complete this section or attach a copy of your Curriculum Vitae

1. Name and Location of Dental School ______________________ Year Graduated __________

2. Subject and location of dental/oral surgery residency(s)

______________________ From ___/___/___ To ___/___/___

______________________ From ___/___/___ To ___/___/___

______________________ From ___/___/___ To ___/___/___

Date residency completed ___/___/___ Date fellowship completed ___/___/___

3. Name all the places where you have practiced (excluding residency or fellowship training)

______________________ From ___/___/___ To ___/___/___

______________________ From ___/___/___ To ___/___/___

______________________ From ___/___/___ To ___/___/___

E. COVERAGE INFORMATION

1. How many hours per week do you practice? S P F N

2. List all professional liability insurance companies that have provided coverage for you in the past five years.

______________________ From ___/___/___ To ___/___/___

______________________ From ___/___/___ To ___/___/___

______________________ From ___/___/___ To ___/___/___

3. Current professional liability insurance company ______________________

4. Current form of insurance ☐ Occurrence ☐ Claims Made Attach a copy of your current Declarations page (facesheet).

- It is not always necessary to buy an Extended Reporting Period Endorsement ("tail") when changing insurance carriers. An alternative is Prior Acts coverage and under most circumstances it is substantially less expensive than purchasing a tail.

- If you are currently insured for professional liability insurance for a practice in Connecticut under an individual claims made policy, you may be eligible for Prior Acts coverage through CMIC.

- Prior Acts coverage provides coverage for claims first made and first reported after the cancellation date of your coverage with your present carrier and the commencement of your policy with CMIC, arising out of treatment rendered since the retroactive or prior acts date of your current policy.

- **CMIC Prior Acts coverage does not cover claims or suits of which you are aware or have reason to be aware prior to your effective date with CMIC. Nor does the policy include coverage for potential claims arising out of acts or omissions in the rendering of dental treatment that you knew or had reason to know, prior to your effective date with CMIC, might reasonably lead to a claim or suit. These matters must be reported to your current company prior to your effective date with CMIC. You should always request confirmation in writing from that company that it will cover claims arising out of these reports.**

5. Desired retroactive date ______/______/__________

6. Have you been and will you continue to be covered by an individual professional liability policy from the retroactive date indicated on your current Declarations page to the effective date of your coverage with CMIC?

   ☐ Yes ☐ No - If No, explain ____

7. Desired effective date ______/______/__________ (Effective date of coverage cannot be prior to the date this application is received by CMIC.)

8. Desired limits of liability (Circle one choice)

   $1,000,000/$3,000,000 [2] $1,000,000/$4,000,000 [7]

9. Specialty ______________________ Sub-Specialty ______________________

10. a. Specialty Credential Status (Circle one choice) 1. Board Certified 2. Board Eligible 3. Other

    b. Name of Specialty Board ____

    c. Date of Certification ______/______/__________ d. Date of recertification (if applicable) ______/______/__________

F. RATING INFORMATION

Indicate which of the following apply to your practice:

____ No general or local anesthesia, analgesia or sedation

____ Local anesthesia only

____ Local anesthesia and/or nitrous oxide/oxygen analgesic

____ Parenteral conscious (including I.M. and I.V. sedation in office)

How often is this administered? ____ daily ____ monthly ____ yearly

Connecticut State Parenteral Conscious Sedation Permit Number__________________ Exp. Date__________

Date of last on-site evaluation ______________________________

____ General Anesthesia in office

How often is this administered? ____ daily ____ monthly ____ yearly

Connecticut State General Anesthesia and Conscious Sedation Permit Number______________ Exp. Date__________

Date of last on-site evaluation ______________________________

Who, other than yourself, administers anesthesia in your office?

____

____ General anesthesia or parenteral conscious sedation in a hospital or accredited surgi-center where anesthesia is under the supervision of an anesthesiologist or CRNA

____ Other, describe (i.e. acupuncture, hypnosis)

1. Which of the following TMJ therapies do you perform: (Check all that apply)

- ☐ Initial Examination
- ☐ TMJ Surgery
- ☐ TMJ Radiography
- ☐ Comprehensive TMJ Therapy
- ☐ Biopsies
- ☐ TMJ Disorder Palliative Therapy
- ☐ TMJ Disorder Referrals

A. Describe specialized TMJ therapy training and duration of training you have received. ______________________________

____

2. Which of the following endodontic procedures do you perform: (Check all that apply)

- ☐ "Conventional" Gutta Percha
- ☐ Sargenti or Sargenti-like
- ☐ Apicoectomies
- ☐ Thermafil or Termafil-like
- ☐ All Endodontics Referred

3. Which of the following tooth replacement implant procedures do you perform: (Check all that apply)

- ☐ Surgical placement of implants
- ☐ Restorative treatment of implants
- ☐ All implant therapy referred

A. Describe specialized training, duration of training and type of implants used: ______________________________

____

4. Which of the following surgical procedures do you perform: (Check all that apply)

- ☐ Erupted third molars extractions
- ☐ Extraction of partially or fully impacted third molars
- ☐ Cosmetic surgical procedures
- ☐ Periodontal surgery
- ☐ Biopsies

G. CLAIMS INFORMATION

TO BE COMPLETED BY ALL APPLICANTS

1. Are you aware of **ANY** circumstances, including but not limited to the following, that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

a. Patient or attorney request for records for reasons other than workers' compensation or accident claims; .... ☐ Yes ☐ No

b. A letter from an attorney regarding your medical treatment of a patient; .... ☐ Yes ☐ No

c. Intra-operative complications or other complications resulting in death, paralysis or other disabilities; .... ☐ Yes ☐ No

d. Patient or family member has expressed significant dissatisfaction with the dental care you provided; .... ☐ Yes ☐ No

e. You are currently or were treating a patient who is suing another dentist, physician or hospital for the same treatment at issue; .... ☐ Yes ☐ No

f. Any other circumstance that might reasonably lead to a claim or suit? .... ☐ Yes ☐ No

2. Has **any** claim or suit for alleged malpractice **EVER** been brought against you or your professional corporation or partnership? .... ☐ Yes ☐ No

If any Yes answers to the above questions, complete the sections on the following page. ☐ ________ / ________

Patient's Name	Age of Patient	Sex

Insurance Provider	Date of Occurrence

Allegations ______________________________

Status of claim, suit or incident | Amount of settlement (or if pending, amount in reserve by carrier) $

Patient's Name	Age of Patient	Sex

Insurance Provider	Date of Occurrence

Allegations ______________________________

Status of claim, suit or incident | Amount of settlement (or if pending, amount in reserve by carrier) $

3. If you answered yes to questions 1 or 2, have all potential claims, claims or suits (regardless of merit) been reported to your current or a prior professional liability company? ☐ Yes ☐ No

H. UNDERWRITING INFORMATION

Please explain, on a separate sheet, any Yes answers.

1. Has **any** hospital or other health care facility **ever** denied, suspended, non-renewed, revoked, declined or in any way restricted your privileges or has probation **ever** been invoked? ☐ Yes ☐ No
2. Have you **ever** voluntarily agreed to surrender or modify your hospital or other health care facility privileges? ☐ Yes ☐ No
3. Have you **ever** been denied a dental license or narcotics license? ☐ Yes ☐ No
4. Have you **ever** been denied a general anesthesia and/or Parenteral Conscious Sedation Permit? ☐ Yes ☐ No
5. Has your dental license or narcotics license **ever** been suspended, revoked, voluntarily surrendered or has probation or any limitations **ever** been invoked? ☐ Yes ☐ No
6. Have you **ever** signed a consent order or consent agreement with, agreed to any sanction by, or been investigated by a state health department, state licensing board or other governmental body? ☐ Yes ☐ No
7. Have any complaints **ever** been registered against you with any employer, dental association/society, specialty board, hospital or other health care facility or state licensing authority or other governmental body? ☐ Yes ☐ No
8. Have you **ever** been denied certification by a specialty board? ☐ Yes ☐ No
9. Has any insurance company **ever** cancelled, non-renewed, denied you professional liability insurance or offered you professional liability insurance only on special or restricted terms or at special rates? ☐ Yes ☐ No
10. Have you **ever** withdrawn an application for professional liability insurance for reasons other than price? ☐ Yes ☐ No
11. Have you **ever** been arrested for any criminal offense? ☐ Yes ☐ No

12. Are any of the actions in Items 1 through 10 above currently under investigation or consideration? .... ☐ Yes ☐ No

13. Do you use any drugs or devices which have been disapproved or not yet approved by the FDA for any use in human beings? .... ☐ Yes ☐ No

14. Do you now or have you **ever** had any defect, illness or disorder, whether physical, mental or emotional, that limits or impairs, has limited or impaired or COULD limit or impair your ability to practice to any degree? .... ☐ Yes ☐ No

15. Do you now or have you **ever** had a drug or alcohol addiction or dependency? .... ☐ Yes ☐ No

Please read the following carefully, then sign and date the application in the space provided below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. **I AGREE** to notify the Connecticut Medical Insurance Company (the "Company") promptly of any material changes in the information I have provided herein. **I UNDERSTAND** that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes herein between the Company, any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance. This authorization does not create any obligation for the Company to release or exchange such information.

DISCLOSURE AUTHORIZATION

I AUTHORIZE all professional societies, my prior or present business or dental associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record of knowledge concerning any of the statements and answers made by me herein to release such information the Connecticut Medical Insurance Company ("Company") and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues. **I AUTHORIZE** the Company and such representatives to use a copy of this authorization in place of the original.

This authorization shall be valid for the period during which I am insured by or am seeking insurance from the Company. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

____ ____________________

Signature of Applicant Date

____ ____________________

Signature of Authorized Representative Date