Dental Corporation Professional Liability Insurance Application

ProAssurance Treated Fairly

ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • 205.877.4400 • Fax 205.868.4040

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for prior acts coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.
4. Current business letterhead.

1. Organization Information

Organization Name: _____

Federal Tax ID: _____-_____ NPI Number: _____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Preferred Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ Email: _____

Is this contact the authorized representative for access to policy information at ProAssurance.com? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative. _____

Please list additional practice locations:

Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership

☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other _____

B. Has the Organization ever been incorporated under a name other than that listed above? Yes ☐ No ☐
If yes, please list all previous names and the first use date of each:

_____

C. Is or has the Organization ever been incorporated in a state other than that listed above? Yes ☐ No ☐
If yes, please list states and first use date in each:

_____

D. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

2. Coverage Information

A. Requested Effective Date: _____ / _____ / _____
MONTH DAY YEAR

B. Requested Limits

i. ☐ Shared Limits ☐ Separate Limits

ii. If requesting separate limits:

a. Primary Coverage Limits: _____

b. Excess Coverage Limits: _____

C. Is the organization requesting Prior Acts Coverage? Yes ☐ No ☐

Requested Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance company that your request for Prior Acts Coverage has been approved.

3. Insurance History and Claims Information

A. Current Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Have any claims or suits ever been filed against your organization as a result of professional services? Yes ☐ No ☐

D. Are you aware of any conduct, circumstances, occurrences, or incidents likely to give rise to a claim? Yes ☐ No ☐

E. If you are answered "yes" to question 3.C. or D., have the claims, conduct, circumstances, occurrences, or incidents been reported to a previous insurer? (Please complete the Supplementary Claims information form at the end of this application.) Yes ☐ No ☐

F. Has the Organization (or those listed in 1.B.) ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance? Yes ☐ No ☐

G. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes ☐ No ☐

4. Practice Information

A. List all healthcare providers, members, shareholders, partners, owners, employed dentists and independent contractors in the organization. It is the policy ProAssurance to insure all dentists who are employees, partners, shareholders and/or owners of a corporation. **All affiliated dentists must complete an application.**

Name: _____ Please check any that apply:

Specialty: _____ ☐ Member ☐ Owner ☐ Shareholder

Start Date: _____ ☐ Employee ☐ Partner ☐ Independent Contractor

Current Insurer: _____ ☐ Other _____ Hrs/Week

Name: _____ Please check any that apply:

Specialty: _____ ☐ Member ☐ Owner ☐ Shareholder

Start Date: _____ ☐ Employee ☐ Partner ☐ Independent Contractor

Current Insurer: _____ ☐ Other _____ Hrs/Week

You must provide proof of coverage for each dentist insured elsewhere.

B. Do you employ any of the following? Yes ☐ No ☐
If yes, indicate the number in each category:

Dental Assistant: _____ Dental Technician: _____ Dental Hygienist: _____

ALABAMA FRAUD WARNING – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Consent to Conditions of Consideration of the Application for Insurance

On behalf of the Organization, I understand that no coverage will be bound until after ProAssurance has reviewed this completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, any advance payment will be promptly returned to the Organization.

On behalf of the Organization, I accept the following conditions during the processing and consideration of this application—regardless of whether or not granted insurance—and for the duration of the insurance which may be issued.

To the fullest extent permitted by law, I, on behalf of the Organization, extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to this application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

The Organization understands that should any incident, injury or death occur to any patient while under our care subsequent to my signing and dating this application, we must notify ProAssurance or its authorized agent or broker in writing of such event.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Applicant's Representations and Authorization which requires your signature. Please read it carefully.

Applicant's Representations and Authorization

I, the undersigned, on behalf of the Organization, hereby authorize present and prior professional liability carriers, any and all attorneys who have represented us in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding the Organization, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon our acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

On behalf of the Organization, I understand that third-party information, records or data regarding our practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

On behalf of the Organization, I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

On behalf of the Organization, I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

On behalf of the Organization, I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Note: ProAssurance's Privacy Policy can be found at ProAssurance.com.

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Dental Corporation Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Name and Address of the Attorney assigned to your case: _____

   _____
5. Date of Incident and your treatment: _____
6. Allegations: _____

   _____

   _____
7. What is the present condition of the patient? _____

   _____

   _____
8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes ☐ No ☐
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed, but dropped by claimant	☐ Jury verdict	☐ Awaiting court action
☐ Summary Judgment in your favor	☐ Directed verdict	Reserve Amount: _____
☐ Suit settled Out-of-Court	☐ Court outcome in favor of plaintiff	
Date claim paid: _____	☐ Jury verdict	
Amount paid: _____	☐ Directed verdict	
	Amount of Loss: _____	

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
    If yes, amount was: $_____

Name (Printed): _____

Signature: _____ Date: _____

PROASSURANCE
Treated Fairly

Important Notice About the Policy of Insurance for Which You Have Applied

This Document Affects Your Legal Rights

Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

Applicant's Signature	Date	Time

Note: You will need to sign this notice to be considered for coverage.