



ProNational
INSURANCE COMPANY
www.ProNational.com

Customer Service Center
2600 Professionals Drive, Box 150
Okemos, Michigan 48805-0150
800/292-1036 517/349-6500 Fax 517/347-6319

GENERAL

For Company Use Only
Agent # _____
Agent _____

DENTAL PROFESSIONAL LIABILITY APPLICATION

SECTION 1

1. Name of Applicant: _____
(LAST) (FIRST) (M.I.)

Mailing Address: _____
(STREET) (CITY/STATE) (ZIP)

Office Address: _____
(STREET)

(CITY) (COUNTY)

(STATE) (ZIP)

Office Telephone #: (_____) _____ Office Facsimile #: (_____) _____

Residence Address: _____

Residence Telephone #: (_____) _____ Social Security #: _____

Date of Birth: _____ Sex: Male Female

Dental License No.: _____ State: _____ Expiration: _____

Name of Partnership or Professional Corporation: _____

Business manager or contact person in your office: _____ Telephone # (_____) _____

Is there an address, other than the mailing address above to which you would prefer all correspondence to be sent? If yes, indicate below.

(STREET) (CITY/STATE) (ZIP)

2. Describe your Dental School Education:

Dental School: _____
(SCHOOL) (CITY/STATE) (COUNTRY)

Degree: _____ Year Completed: _____

3. Type of Practice: General Dentistry Specialty

4. If you hold a certificate of completion from an ADA accredited specialty training program in any area of dentistry, please complete the following.

Name of specialty _____

Name of institution _____

Date of completion _____

5. Any other specialty? _____

6. Current Hospital Staff Appointments:

(Hospital) _____

(Hospital) _____

7. Dental Specialty Society Affiliations:

(Society) _____

(Society) _____

(Society) _____

8. Are you a member of a Dental Association? Yes No

SECTION 2

1. What percentage of your practice is in the following areas? (Please account for 100% of your practice.)

a) Endodontics _____%

1. Do you use the Sargenti Method? Yes No
If yes, do you obtain a signed consent form from each patient. Yes No

b) Orthodontics _____%

1. What pre-diagnostic procedures do you take?

- cephalometric x-rays
- pantographic/panoramic x-rays
- study casts and photographs
- full mouth surveys
- other _____

2. Do you perform comprehensive orthodontic services? Yes No
If yes, please complete the following.

a) Describe types of services performed

b) Describe courses taken, indicating institution and hours of clinical and/or didactic instruction.

c) Periodontics _____%

1. Does care include surgical treatment? Yes No
If yes, list pertinent procedures.

d) Pedodontics _____ %

e) Prosthodontics _____ %

f) Oral and Maxillofacial Surgery _____ %

1. Do you perform either of the following?

Surgical removal of impacted teeth

Maxillary and/or mandibular osteotomies

2. Do you perform any other oral/maxillofacial surgical procedures? Yes No

If yes, please complete the following.

a) List pertinent procedures.

b) List hospitals, clinics or other facilities where you perform these procedures.

3. Do you act as an assistant surgeon for any oral/maxillofacial surgical procedures? Yes No

If yes, please complete the following.

a) List pertinent procedures.

b) List hospitals, clinics or other facilities where you perform these procedures.

g) General Dentistry (incl. simple extractions, but not procedures listed above) _____ %

h) TMJD Services _____ %

1. Do you limit your practice to non-surgical TMJD treatment? Yes No

2. Do you provide occlusal adjustment therapy? Yes No

3. Do you provide splint therapy? Yes No

4. Do you ever provide orthodontic treatment to TMJD? Yes No

5. Have you obtained additional training in TMJD since graduation from dental school? Yes No

If yes, describe course taken indicating institution and hours of clinical and/or didactic instruction.

2. Do you perform cosmetic dentistry? Yes No

If yes, list types of procedures performed. _____

3. Do you place implants? Yes No

If yes, please complete the following.

a) Types of implants _____
Number of cases per year _____
Special training received (school, hours) _____

4. If you do not place implants, are you providing prosthetic restorations on implants only? Yes No

5. Do you perform any diagnostic or therapeutic procedures which have been introduced to you and/or the dental profession within the past 18 months? Yes No

If yes, please explain. _____

SECTION 3

1. Check all methods used to control pain and apprehension in your practice.

- Local anesthesia
- Nitrous oxide/oxygen analgesia
- Oral sedation by the use of drugs swallowed by patient
- Conscious sedation provided by subcutaneous, intramuscular or intravenous injection
- General anesthesia or conscious sedation in a hospital or surgicenter where the anesthesia is under the supervision of an anesthesiologist or C.R.N.A.
- General anesthesia in your office, where the anesthesia is under the supervision of an anesthesiologist or C.R.N.A.
- General anesthesia in your office, where the anesthesia is under your supervision
- None of the above

a) Please describe your training in anesthesia/sedation.

Name of institution(s) _____

b) If you administer general anesthesia or conscious sedation, which of the following monitors do you use?

- Manual/electronic monitoring of blood pressure and heart rate
- Pulse-oximeter
- Other _____
- None

c) List the agents used in your sedation techniques.

2. Which of the following items do you have available for emergency treatment?

- Oral airway
- Oxygen
- Endotracheal tubes/scopes
- AmbuBag
- Emergency drugs
- None

3. Are you trained in CPR? Yes No

If yes, please complete the following.

a) Certification _____

b) Expiration Date _____

4. Are any of your employees trained in CPR? Yes No

If yes, please complete the following.

a) Job position	Certification	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4

1. Do you practice in any other state? Yes No

If yes, list state(s) and amount of time you practice in each. _____

2. Do you perform acupuncture? Yes No

If yes, submit certificates of completion from courses taken, indicating the number of hours of clinical and/or didactic instruction.

3. Do you practice Homeopathy? Yes No

If yes, please complete the following.

a) What percentage of your practice is devoted to homeopathy? _____%

b) What type of formal homeopathic education (schools, courses) have you had? _____

c) What type of homeopathic clinical training (preceptorship/experience) have you had? _____

d) Do you participate in any study groups pertaining to homeopathy? Yes No

4. Do you employ assistants? Yes No

If yes, please complete the following.

a) Indicate number of each.

_____ Hygienists

_____ Dental Assistants

_____ Other (Please describe) _____

b) Are they registered by the State? Yes No

5. Location(s): Please list all offices or clinics where you practice. If additional space is needed, please attach a separate sheet.

_____ (ENTITY) (ADDRESS)

_____ (TELEPHONE #) (BUSINESS MANAGER / CONTACT PERSON)

_____ (ENTITY) (ADDRESS)

_____ (TELEPHONE #) (BUSINESS MANAGER / CONTACT PERSON)

6. Identify dentists, physicians and surgeons working at above locations. If additional space is needed, please attach a separate sheet.

SECTION 5

1. ANSWER THE FOLLOWING QUESTIONS: If the answer is yes to any of the questions below, provide a detailed explanation in the space provided on page 10 or attach on a separate sheet.

	Yes	No
a) Have you ever been diagnosed/treated for alcoholism, narcotics addiction or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you ever been convicted of any civil or criminal act by any State or Federal authority?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you ever had a complaint filed against you by any State Board of Dentistry?	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you ever had any State dental license or Federal narcotic license revoked, restricted, limited, denied, suspended, subject to probationary conditions, voluntarily relinquished or otherwise sanctioned?	<input type="checkbox"/>	<input type="checkbox"/>
e) Have you ever had your hospital staff or similar privileges refused, restricted, modified, suspended or voluntarily surrendered?	<input type="checkbox"/>	<input type="checkbox"/>
f) Have you ever had a case reviewed before a peer review committee?	<input type="checkbox"/>	<input type="checkbox"/>
g) Have you ever had your membership in a professional society refused, suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you ever had a claim or been sued for dental professional liability? (If yes, please submit on the supplemental claims form, pages 11 and 12 attached. Make additional copies of the form if needed.)	<input type="checkbox"/>	<input type="checkbox"/>
i) Have you ever had professional liability insurance refused, cancelled or non-renewed?	<input type="checkbox"/>	<input type="checkbox"/>
j) Are you a member of a capitation program?	<input type="checkbox"/>	<input type="checkbox"/>
k) Have you ever been diagnosed as having or tested positive for Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>
l) Have you tested positive for the antibody?	<input type="checkbox"/>	<input type="checkbox"/>
m) Have you ever been diagnosed as having or tested positive for HIV or Acquired Immunodeficiency Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6

FOR CONSIDERATION OF PART-TIME COVERAGE, PLEASE COMPLETE THE FOLLOWING:

1. Has your practice been reduced because of any of the following? (Check all that apply)

- Semi-retirement
- Disability
- Majority of practice is conducted in a teaching role which is insured elsewhere
- Majority of practice is insured through another entity such as an employer
- Pregnancy or dependent care
- Maintenance of another practice in bordering state which is insured elsewhere

a) List Employer(s) and/or Hospital(s) for which coverage is needed.

If additional space is needed, please attach separate sheet.

Name/Address _____

1) Number of hours worked per week at the above location _____

2) Specialty practiced at the above location _____

b) List all other locations of employment for which coverage is not needed.

If additional space is needed, please attach a separate sheet.

Name/Address _____

1) Number of hours worked per week at the above location _____

2) Specialty practiced at the above location _____

3) Insurance carrier providing coverage at the above location _____

(NOTE) PLEASE SIGN AND DATE NEXT PAGE

APPLICANT'S AUTHORIZATION AND CERTIFICATION

I authorize the release of all information to ProNational Insurance Company (hereafter "ProNational") from any medical school or hospital where I have received training; any person(s) who has information concerning my fitness to practice, including persons with whom I received training; any hospital at which I have applied for privileges, whether those privileges were granted or not; past and present medical associations, societies, specialty boards and any regulatory body granting me a license to practice medicine in any state; any insurance company to which I have applied for medical malpractice coverage, whether such coverage was granted or not; and any employer for whom I performed medical services, whether as an employee or an independent contractor.

I understand that information requested by ProNational may include, but not necessarily be limited to, any occurrence, incident, claim or suit in which I may be or may have been involved; any denial, suspension, revocation, or disciplinary investigation, recommendation or action relating to staff privileges at a hospital, clinic, employer or any other person connected with my providing medical services; any disciplinary action taken by any medical licensing authority; or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities. I understand that the information will be used in addition to my application in determining whether ProNational will issue insurance to me.

I agree that the persons providing the information and their agents, directors and employees, shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I understand that this is an application for insurance, and shall not bind ProNational to the issuance of insurance, nor shall it bind me to the acceptance of a policy.

Ohio

Any person who, with intent to defraud or knowing that he 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.

Pennsylvania

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.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files for 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.

Florida

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 in the third degree.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT: (1) IF THE POLICY IS ISSUED, THIS IS DONE BY PRONATIONAL IN RELIANCE UPON THESE REPRESENTATIONS; AND (2) ANY POLICY OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION IS VOID.

SIGNATURE OF APPLICANT

DATE OF SIGNATURE

PLEASE PRINT NAME

SOCIAL SECURITY NUMBER

SUPPLEMENTAL CLAIMS INFORMATION FORM

As indicated in Section 5, Question 1h of the Dental Professional Liability Application (Form ProNational GN28A), the following information is required. Please complete a separate form for each claim or suit reported. Note: THERE IS NO NEED TO REPORT CLAIMS ALREADY BEING HANDLED BY PRONATIONAL.

1. Name, age and sex of patient: _____

2. Date of first consultation: _____

3. Physical condition and diagnosis at above date: _____

4. Dates of treatment given and nature of same: _____

5. Date of claim, and allegations made against you: _____

6. Disposition of claim, amount of judgement or settlement: _____

7. What insurance company, if any, was involved: _____

8. Subsequent condition of health of patient: _____

9. Names of other doctors, if any, involved in the claim or suit: _____

10. To whom may we refer for further information about the suit: _____

DATE COMPLETED

SIGNATURE OF APPLICANT

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DATE COMPLETED

SIGNATURE OF APPLICANT