SECURE NET INSURANCE SERVICES, INC.
CA, AZ, NV
Our Business Is To Protect Your Business

CLAIMS-MADE

Professional Liability Insurance For Dentists

www.WeInsureMalpractice.com

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: IN, SC)**	

PLEASE TELL US ABOUT YOURSELF

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. Business structure under which you practice:

A. Do you own your dental practice?.....❑Yes ❑No

B. Are you: ❑ Incorporated ❑ Partnership ❑ L. L. C. ❑ L. L. P. ❑ Sole Proprietor

- Provide the name of the Legal Entity_____

C. Besides yourself, list the names of all dentists who are partners/corporate officers: (use a separate sheet if necessary)
(Note: All partners/corporate officers must be insured by Our Company)

Name	Social Security No.	Name	Social Security No.

D. If you own your own practice, how many:

	# of full-time	# of part-time
Employee dentists work for you?…….. (Attach separate application or proof of professional liability insurance)		
Independent Contractor dentists work for you?…….. (Attach proof of professional liability insurance)		
Other employees work for you? (other than dentists)……		
Total		

E. Do you work for another dentist as an independent contractor dentist?..... ❑Yes ❑No
If "**Yes**", at how many locations do you practice each week?_____

F. Do you work for another dentist as an employee dentist?.....….....❑Yes ❑No
If "**Yes**", at how many locations do you practice each week?_____

G. Do you share dental facilities with another dentist other than employees or independent contractors?... ❑Yes ❑No
If "**Yes**", attach proof of professional liability insurance for the other dentists

ABOUT YOURSELF (continued)

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

1) _____
Street City County State Zip Code %

2) _____
Street City County State Zip Code %

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 ❑ Pediatric Dentistry ❑ Oral/Maxillofacial Surgery *
❑ Endodontics ❑ Periodontics ❑ Anesthesiology(Dental)-Conscious Sedation *
❑ Oral Pathology ❑ Prosthodontics ❑ Anesthesiology(Dental)-General Anesthesia *
❑ Orthodontics

* Supplemental Questionnaire must be completed

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

❑ TMJ-Phase II (irreversible treatments such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)
❑ Implant Surgery ❑ "Sargenti" or similar endodontic technique
❑ Extraction of Impacted teeth ❑ Implant Restoration ❑ Molar Endodontics on Permanent Teeth
❑ Sleep Apnea Therapy* ❑ Weight Loss Therapy*

*If Sleep Apnea or Weight Loss Therapy is performed, please indicate the following: (check all that apply)**
Sleep Apnea: ❑ I fabricate snore guard ❑I treat only after referral from physician ❑ I treat without physician referral
Weight Loss: ❑ I treat only after referral from physician ❑ I treat without physician referral

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

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

18. 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

19. 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.

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

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."

20. 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 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 TELL US ABOUT YOUR INSURANCE HISTORY

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

_____

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

_____

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

24. 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.

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

Insurer	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability

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

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

28. 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 any carrier contacted by Secure Net Insurance Services 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 applies only to claims that are first made against the insured during the policy period. Claim expenses reduce the limit of liability. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for acts or omissions 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 acts or omissions which may have occurred during the term of the "Claims-Made" policy, but no claim was made against me or reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage for such acts or omissions.

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, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.

Applicable in New York: Fines will not exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Colorado: Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder or claimant, with regard to settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

_____

Signature in full: Date

REMINDER:

Please attach a sample of your letterhead and a copy of all of your dental practice "Yellow Pages" advertising, if any, to this application.

RETURN TO:

Secure Net Insurance Services, Inc.
18425 Burbank Blvd., Suite 714
Tarzana, California 91356

Phone # : **(800) 723-5003** Fax # : **(818) 343-4075**

E-Mail : info@securenetinsurance.com

License Number: **CA: 0D25363, AZ: 134692, NV: 15786**