KINSALE® INSURANCE

DENTISTS & ORAL SURGEONS NEW BUSINESS APPLICATION

Instructions to the Applicant – Please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.

If a question is not applicable, then state "N/A".

The following information must be submitted with the completed application:

- ☐ Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
- ☐ Copy of your Curriculum Vitae
- ☐ 5-year company loss runs, valued within the last 30 days

PERSONAL INFORMATION

Applicant's Name: _____ ☐ DDS ☐ DMD

Date of Birth _____ / _____ / _____ Last four digits of SSN: _____ Are you a U.S. Citizen? ☐ YES ☐ NO

Home Address: _____
STREET CITY COUNTY STATE ZIP

Mailing Address: _____
STREET CITY COUNTY STATE ZIP

Website: _____ Email: _____

Provide the following information for all states in which you are license to practice:

State	% of Practice	License #	Active	Inactive	Temporary	Pending
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Federal DEA License Number: # _____ Status: _____

PRACTICE SPECIALTY AND EDUCATION

1. Please indicate your specialty:

- ☐ General Dentistry
- ☐ Pediatric Dentistry
- ☐ Orthodontics
- ☐ Endodontics
- ☐ Oral Radiology
- ☐ Periodontics
- ☐ Prosthodontics
- ☐ Other: _____
- ☐ Oral Pathology
- ☐ Oral and Maxillofacial Surgery
- ☐ Dental Anesthesiology

2. Complete the following:

	Name of Institution	Degree/Specialty	Completed?	Year Completed
Dental School	_____	_____	☐ YES ☐ NO	_____
Residency	_____	_____	☐ YES ☐ NO	_____
Additional Training	_____	_____	☐ YES ☐ NO	_____

3. Are you a Foreign Dental School Graduate? ☐ YES ☐ NO Date you began practicing in the U.S. ____/_____

4. Indicate the number of CE hours you have completed in past two years: _____

5. Have you participated in any risk management/loss prevention services in the past 12 months? ☐ YES ☐ NO

6. Of which dental societies and/or associations are you a member?_____

_____

PRACTICE INFORMATION

7. Type of Practice:

- ☐ Solo Unincorporated
- ☐ Solo Incorporated
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Professional Association
- ☐ Employed Dentist: By Whom: _____
- ☐ Contracted Dentist: By Whom: _____

8. Entity Name:_____ Applicant's Ownership: _____%

9. Are you requesting that the entity be named on your policy? ☐ YES ☐ NO

11. Principal Practice Address:

_____ _____ % of Practice
STREET CITY STATE ZIP

12. Additional Practice Location(s):

_____ _____ % of Practice
STREET CITY STATE ZIP

_____ _____ % of Practice
STREET CITY STATE ZIP

13. List all locations and dates where you have practiced in the last 10 years:

Practice Name	City/State	Specialty	From	To

OFFICE STAFF

14. Do you employ, contract with, or supervise any dentists? If yes, provide details on page 7. ☐ YES ☐ NO

15. Do you share office space or have an expense sharing arrangement with any other dentist not mentioned above? If yes, please provide details on page 7. ☐ YES ☐ NO

16. Please complete the staff table:

Type	Number Employed	Coverage Desired	Number Contracted	Insured Elsewhere?
Dentist*		☐ YES ☐ NO		☐ YES ☐ NO
Dental Assistant		☐ YES ☐ NO		☐ YES ☐ NO
Dental Technician		☐ YES ☐ NO		☐ YES ☐ NO
Dental Therapist		☐ YES ☐ NO		☐ YES ☐ NO
Hygienist		☐ YES ☐ NO		☐ YES ☐ NO
Physician*		☐ YES ☐ NO		☐ YES ☐ NO
Physician Assistant		☐ YES ☐ NO		☐ YES ☐ NO
Surgeon Assistant		☐ YES ☐ NO		☐ YES ☐ NO
CRNA*		☐ YES ☐ NO		☐ YES ☐ NO
Nurse (RN, LPN, LVN)		☐ YES ☐ NO		☐ YES ☐ NO
X-Ray Technician		☐ YES ☐ NO		☐ YES ☐ NO
Other		☐ YES ☐ NO		☐ YES ☐ NO
* Separate application must be submitted for each if coverage is desired				

SPECIFICS OF PRACTICE/PROCEDURES

17. Average Weekly Practice Hours: _____

18. Average Weekly Patient Encounters: _____

19. Do you work for any Locum Tenens companies as an employee or independent contractor? ☐ YES ☐ NO
If yes, indicate number of hours worked each month: ____

20. Does the Locum Tenens Company provide you with Professional Liability insurance? ☐ YES ☐ NO
If yes, provide a copy of the COI.

21. Have there been any changes in your specialty or practice activities within the past 10 years? ☐ YES ☐ NO
If yes, explain: _____
_____

22. Do you anticipate any changes in your specialty or practice activities in the next year? ☐ YES ☐ NO
If yes, explain: _____
_____

23. Do you perform any procedure not routinely performed by others practicing in your specialty or subspecialty? If yes, explain: _____ ☐ YES ☐ NO

_____

24. Provide the following information for all hospitals and surgery-centers where you are currently on staff:
(If no hospital privileges, attach protocol for patient admission)

Name of Facility	City/State	% of Work	Type of Privileges

25. Are you employed full-time or part-time by the federal, state, or local government, or are you on active military duty? If yes, explain on page 7. ☐ YES ☐ NO

26. Do you treat patients in a nursing home, similar care facility, or correctional facility? ☐ YES ☐ NO
If yes, provide the percentage of practice in each:

Name(s) of Facilities:

____% nursing home _____

____% similar care facility _____

____% correctional facility _____

27. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? If yes, please explain on page 7. ☐ YES ☐ NO

28. Do you endorse any products or participate in any activity which offers professional advice to the public, including but not limited to newspaper columns and broadcasts? If yes, please explain on page 7. ☐ YES ☐ NO

29. Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering dental services? If yes, please explain on page 7. ☐ YES ☐ NO

30. Do you wire jaws closed for the purpose of weight loss? If yes, provide annual number performed _____ ☐ YES ☐ NO

31. If you use Local Anesthesia only, check here ☐

If other types of anesthesia are administered, please complete the table below:

	Inhalation Conscious Sedation	**Oral Conscious Sedation**	**Parenteral Conscious Sedation**	**Parenteral Deep Sedation**	**General Anesthesia**
% of patients under age 18					
Drugs used					
Location performed: Office (O), Surgi-Center (S), Hospital (H)					
Administered by: You, Oral Surgeon, Anesthesiologist, CRNA, Other (specify)					

32. Do you possess any ALS certifications? ☐ YES ☐ NO If yes, specify: _____

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

____ Oral airway	____ Ambu bag	____ Endotracheal tubes/scopes
____ Oxygen	____ Emergency drugs	____ None available

34. Provide the approximate percentage of your practice in the following:

Cosmetic Dentistry		Oral Pathology	____%
Bonding	____%	Oral Radiology	____%
Enamel Shaping	____%	Orthodontics	____%
Full Mouth Restoration	____%	Pediatric Dentistry	____%
Veneers	____%	Periodontics	____%
Whitening with Lasers	____%	Prosthodontics	
Other Procedures	____%	Fixed	____%
_____		Removable	____%
Non-Dental Cosmetic Procedures		Non-Surgical Sleep Apnea Therapy	____%
(Botox, Collagen, fillers, etc.)	____%	Surgery	
Endodontics		Facial – Elective Cosmetic	____%
Single Rooted	____%	Head and Neck	____%
Multi Rooted	____%	Oral/Maxillofacial	____%
Sargenti Root Canal Method	____%	Outside oral/maxillofacial region	____%
Extractions		Orthognathic Procedures	____%
Simple Extractions	____%	Bone Grafting	____%
Impacted - Soft Tissue	____%	Sleep Apnea Surgery	____%
Impacted - Partial Bony	____%	Microneurosurgical Procedures	____%
Impacted - Full Bony	____%	TMJ	
Implants		Non-Surgical	____%
Restoration	____%	Surgical	____%
Placement	____%	**TOTAL**	**100%**

35. If you have performed any implant procedures within the last year, please answer the following:

I have not performed any implant procedures within the last year: _____*(initial)*

1. Osseointegration only _____# procedures
2. Endosteal - Ramus Frame _____# procedures
3. Endosteal - Other _____# procedures
4. Subperiosteal (above bone but beneath gum) _____# procedures
5. Transosseus (penetrate entire jaw) _____# procedures
6. Other _____ _____# procedures

36. Do you perform sinus lifts or other surgical procedures in conjunction with implant procedures? ☐ YES ☐ NO
If yes, how many are performed annually? _____

37. If you perform sleep apnea therapy, do you treat only after referral from a physician? ☐ YES ☐ NO

PRIOR POLICY AND LOSS INFORMATION – Provide details for all "YES" answers on Page 7

38. Has your dental or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ YES ☐ NO

39. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ YES ☐ NO

40. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ YES ☐ NO

41. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ YES ☐ NO

42. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? ☐ YES ☐ NO

43. Has any fee or professional relations complaints been registered against you with your dental association, hospital, or a state licensing authority? ☐ YES ☐ NO

44. Provide the following information pertaining to your past 5 years of professional liability insurance coverage:

Carrier	Policy Period	Policy Limits	Deductible	Retro Date

45. Have you ever practiced without professional liability insurance? ☐ YES ☐ NO

46. Do you have professional liability insurance for work you do elsewhere? ☐ YES ☐ NO

47. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? ☐ YES ☐ NO

48. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? ☐ YES ☐ NO

49. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ YES ☐ NO

50. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO

51. Are you aware of any acts, errors, omissions, or circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit? ***If yes, please complete a supplemental claims form for each circumstance.*** ☐ YES ☐ NO

SUPPLEMENTAL INFORMATION

Use this page to as needed to address questions referenced within the application or to provide information you deem pertinent to our review of your application.

STATEMENT OF NO KNOWN CLAIMS OR CIRCUMSTANCES

- I have no known losses or claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;
- I have no knowledge of acts, omissions or circumstances that relate to a professional service which could reasonably result in a claim, that has not been reported to a prior insurance carrier;
- I have no knowledge of any request for medical records by a patient or their attorney which might result in a claim;
- I have no knowledge or information relating to service or services on a Board which might result in a claim; and
- I have no knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result, or attorney contact.

My signature on Page 9 confirms the above statements

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant (Print Name): _____ Title: _____

Applicant's Signature: _____ Date: _____

Agent / Broker Name: _____

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, please photocopy this form and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed/dated.

Name of Patient/Claimant: _____ Age: _____ Sex: _____

Date of Alleged Incident: _____ Date Reported to Insurance Company: _____

Name of Insurance Company: _____

Additional Defendant(s): _____

Allegation: _____

_____

Description of Medical Services Rendered to Patient: _____

_____

_____

Present Condition of Patient: _____

Status of Claim:

☐ Dismissed (no payment made to claimant)

☐ Defense Verdict

☐ Plaintiff Verdict Total Awarded: $ _____ Amount Paid on Your Behalf: $ _____

☐ Settlement Total Awarded: $ _____ Amount Paid on Your Behalf: $ _____

☐ Open Loss Reserves: $ _____ Plaintiff's Demand: $ _____

To your knowledge, was any settlement paid by another party involved? ☐ YES ☐ NO

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim: _____

_____

_____

Applicant's Signature: _____ Date: _____

Applicant (Print Name): _____