Application Instructions

If you have been uninsured prior to applying for coverage, please include an explanation for the period of time that you have been uninsured:

Are you applying for Claims-Made coverage with prior acts? If so, we must receive a copy of your current policy or a certificate of insurance that includes you prior acts date (also known as retroactive date).

Please be certain to include copies of patient health history and informed consent forms used in your practice.

Please include a copy of your dental license

If you have had claims, please include complete information about the claims, including the date services were rendered, the date the claim was made, the amount paid or the amount in reserve and the status of the claim, is the claim still open, closed without payment or closed with payment.

Additional Forms May be Required:

> **Part-Time**: If you are practicing less than 20 hours and you request the Part-Time discount, a Part-Time Supplement must be completed and submitted.

Individual Major Medical

Short Term Medical
- Students
- New Employees
- Between Jobs

International Travel and Trip Cancellation Insurance

Disability Income

Business Overhead Expense

Term Life

Employer Group Plans

Bryan Lau, CPA
Serving Dentistry for More Than 30 Years
PO Box 3436, Laurel, MD 20709
(301) 470 - 6126 Fax (301) 470 – 3634
(410) 888 - 9196 Fax (443) 921 – 8371
E-Mail bryanlau@lau2.com
judylau@lau2.com

www.DentistFile.com

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PO Box 3436
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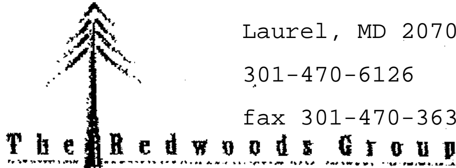
301-470-6126
fax 301-470-3634



NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, P.A

2704 Commerce Drive, Suite B., Harrisburg, PA 17110

ADMINISTRATIVE OFFICES

70 Pine Street, New York, NY 10270

A Capital Stock Insurance Company

Endorsed by:
National Society of Dental Practitioners
Administered by:
The Redwoods Group, Inc.
210 University Drive, 6TH Floor
Coral Springs, FL 33071
(800) 237 -9429

APPLICATION FOR DENTISTS PROFESSIONAL LIABILITY INSURANCE

THIS APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY

IMPORTANT NOTICE

Coverage is available to dentists who are members of the National Society of Dental Practitioners on either an occurrence policy form or a claims made policy form. Please note your choice by answering Question 5 below.

NOTE: THIS POLICY MAY PROVIDE CLAIMS MADE COVERAGE. REFER TO ATTACHED DISCLOSURE NOTICE.

GENERAL INFORMATION ____________ **APP. I.D** ____________

1. **Full Name of Applicant:** ____________ ☐ **Male** ☐ **Female**

   Date of Birth: ____________ **Social Security Number:** ____________

   Home Address:

   ____________ Street ____________ City ____________ County ____________ State ____________ Zip Code

   ____________ Telephone Number ____________ Fax Number ____________ E-Mail Address

2. **If you are the owner of any of the following dental facilities, please submit a separate application for insurance for each dentist employee or provide proof of their insurance coverage.**

   Primary Practice Information - Location #1:

   ____________ Name of Facility

   ____________ Street ____________ City ____________ County ____________ State ____________ Zip Code

   ____________ Telephone Number ____________ Fax Number ____________ E-Mail Address

   Year you were licensed: ______ **Current License Numbers/States:** ____________

   Please submit copies of all current licenses. ____________

   Number of patients you see weekly at this location: ______
   Number of hours you practice weekly at this location: ______
   Total number of patients seen weekly at this location ______
   Number of Dental Assistants at this location: ______
   Number of Dental Hygienists at this location: ______
   Number of dentists practicing at this facility: ______

Please provide the following for each dentist at Location 1 -

Name	Specialty	Hours worked per week

Other Locations Where You Practice
Location #2:

Name of Facility ______ Street ______

City ______ Country ______ State ______ Zip Code ______

Number of patients you see weekly at this location: ______
Number of hours you practice weekly at this location: ______
Number of Dental Assistants at this location: ______
Number of Dental Hygienists at this location: ______
Total number of patients seen weekly at this location ______
Number of dentists practicing at this facility: ______ Please provide the following for each dentist:

Name	Specialty	Hours worked per week

Location #3:

Name of Facility ______ Street ______

City ______ County ______ State ______ Zip Code ______

Number of patients you see weekly at this location: ______
Number of hours you practice weekly at this location: ______
Number of Dental Assistants at this location: ______
Number of Dental Hygienists at this location: ______
Total number of patients seen weekly at this location: ______
Number of dentists practicing at this facility: ______ Please provide the following for each dentist:

Name	Specialty	Hours worked per week

3. To which of the above addresses would you like correspondence sent?
☐ Office Loc. # ______ ☐ Home ☐ Other ______

4. Coverage Effective Dates: From ______ To ______

5. Coverage Form Requested ☐ Occurrence ☐ Claims Made

6. If prior Professional Liability insurance was on a Claims-Made basis, advise the Retroactive Date of the coverage (Date you were first insured under a Claims-Made) ______

ATTACH A COPY OF YOUR CURRENT DECLARATIONS PAGE

7. Indicate Limits of Liability for which you are applying **(Some limits may not be available in all states)**
LIMITS OF INSURANCE - EACH DENTAL INCIDENT/AGGREGATE

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,500,000
☐ $1,000,000/$3,000,000 ☐ $1,300,000/$3,900,000 (NY Only) ☐ $2,000,000/$4,000,000

8. Consent Waiver. May not be available in all states. Do you wish to waive the provision in the policy requiring us to obtain your consent in order to settle a claim against you (a premium reduction will apply)? ☐ Yes ☐ No

PRACTICE, LICENSURE, EDUCATION, AND QUALIFICATIONS

9. Character of Your Practice (check all that apply)
☐ General Dentistry ☐ Periodontics ☐ Prosthodontics
☐ Pediatric Dentistry ☐ Endodontics ☐ Orthodontics
☐ Oral Surgery ☐ Oral Pathology ☐ Public Health
☐ Dental anesthesiology - conscious sedation, not including deep sedation or general anesthesia
☐ Dental anesthesiology - including deep sedation and/or general anesthesia in a hospital setting
Check all of the following that apply:
☐ Your practice is comprised of more than 50% TMJ treatment, all phases
☐ You are board eligible in the specialty(s) checked above
☐ You are board certified in the specialty(s) checked above

10. Dental School ______ ProfessionalDegree ______ Year Graduated ______

Are you a Foreign Dental School graduate? ☐ Yes ☐ No

Foreign Dental School ______ Country ______ Professional Degree ______ Year Graduated ______

11. Practice Information: I provide dental services operating as a(n):
☐ Unincorporated Individual ☐ Partnership ☐ Employee of a Private Dental Practice
☐ Professional Association ☐ Multi-dentist Corporation ☐ Limited Liability Company/Partnership
☐ Independent Contractor ☐ Employee of a Dental Clinic ☐ Incorporated Individual
Please provide full legal name of entity indicated ______

12. Risk Management Course Work: Please attach certificate of completion with respect to any risk management course completed during the past three years. A premium credit may apply.

13. Do you refer overdue patient accounts to a collection agency? ☐ Yes ☐ No
If yes, how may accounts have you referred in the past year? ______

14. Are you a member of any of the following organizations:
☐ American Dental Association ☐ National Dental Association
☐ Academy of General Dentistry ☐ American Academy of Pediatric Dentistry
☐ American Association of Endodontists ☐ American Academy of Periodontology
☐ American College of Prosthodontists ☐ American Association of Orthodontists
☐ American Academy of Implant Dentistry
Check the level applicable to your professional affiliation
☐ Member ☐ Fellow ☐ Master ☐ Diplomat ☐ Board Eligible ☐ Board Certified
Membership Number: ______
List any other professional designations which you have or professional societies with which you are affiliated:
______

GENERAL PRACTICE CHARACTERISTICS

15. During the typical practice MONTH, please estimate the NUMBER OF PROCEDURES for each of the following

	Procedures/Month		Procedures/Month
Endodontics		**Prosthodontics**	
a. Single-rooted endodontics:	______	a. Single unit/Crown:	______
b. Multi-rooted endodontics:	______	b. Multi unit:	______
Sargenti		c. Full mouth dentures:	______
a. N2 Paste used:	______	d. Denture adjustments/repair:	______
b. Sargenti Procedures:	______	e. Implants - restorative stage:	______
Oral Surgery		**Periodontics**	
a. Simple extractions	______	a. Scaling:	______
b. Third molar extractions:	______	b. Surgical periodontics:	______
Soft tissue impactions:	______	**Orthodontics:**	
Partial bony impactions:	______	a. Comprehensive orthodontics:	______
Total bony impactions:	______	b. Minor tooth guidance:	______
c. Surgical implants:	______	c. Percentage of adult patients:	______
d. Describe all other surgical procedures you do:		d. Percentage of minor patients:	______

____

16. If you use any pretreatment medication, other than local anesthetics, please indicate the drug(s) used and method of administration: ______________________________

____

17. Do you examine all new patients for the presence of periodontal ☐ Yes ☐ No
At every recall visit? ☐ Yes ☐ No
If Yes to either question, what technique is used? ☐ Visual ☐ Periodontal Probing ☐ Other ______
If present, do you: ☐ Refer ☐ Treat If you treat, method: ☐ Surgically ☐ Non-surgically

18. ORAL SURGERY
a) Is your practice limited to Oral Surgery? ☐ Yes ☐ No
b) Do you employ anyone who performs Oral Surgery? ☐ Yes ☐ No
c) Do you have an Independent Contractor come into your office to perform Oral Surgery? ☐ Yes ☐ No
d) Do you obtain a written informed consent for third molar extractions? ☐ Yes ☐ No ☐ Don't perform

19. ANESTHESIA
a) Do you treat patients who are rendered unconscious BY YOU through the administering of anesthetics, analgesics, intravenous or intramuscular sedatives, or general anesthesia? ☐ Yes ☐ No
If Yes, please explain: ______________________________

____

b) Do you treat patients who are rendered unconscious BY OTHERS through the administering of anesthetics, analgesics, intravenous or intramuscular sedatives, or general anesthesia? ☐ Yes ☐ No
If Yes, please explain: ______________________________

____

c) Do you provide treatment to any patient who has been sedated with nitrous oxide? ☐ Yes ☐
If Yes, does your equipment have FAIL-SAFE DEVICES? ☐ Yes ☐ No

d) Do you provide treatment to any patient who has been sedated with chloral hydrate? ☐ Yes ☐ No

e) Do you provide treatment to any patient who has been sedated with Halcion,Triazolam or other hypnotic drugs? ☐ Yes ☐ No
If yes, Mild Sedative? ☐ Yes ☐ No Unconscious State? ☐ Yes ☐ No

20. **SURGICAL IMPLANTS**

a) Do you perform surgical implants? ☐ Yes ☐ No

If Yes, specify phase(s) ☐ Surgical Phase ☐ Restorative Phase ☐ Both

b) Are you a general dentist who has completed a one-year general residency program? ☐ Yes ☐ No

Do you have at least 150 hours of continuing education or a maxi-course regarding implant treatment? ☐ Yes ☐ No

c) Do you obtain a written informed consent for surgical placement of implants? ☐ Yes ☐ No

If Yes, please attach a copy of the form used.

21. Do you perform any procedures with the use of Laser Technology? ☐ Yes ☐ No

22. Do you offer any services for the purpose of appearance or skin enhancement, hair removal or replacement, personal grooming or therapy or other cosmetic purposes? ☐ Yes ☐ No

If yes, please explain: ____________________

23. Do you employ any dentists as employees or independent contractors? ☐ Yes ☐ No If Yes, how many? _____

a) Are any of these employees or independent contractors dentists who treat your patients as oral and maxillofacial surgeons? ☐ Yes ☐ No If no, please explain: ____________________

b) Do any of these employees or independent contractors treat patients who are rendered unconscious through the administration of anesthetics, analgesics, intravenous or intramuscular sedatives or general anesthesia? ☐ Yes ☐ No

24. Do you take a written health history on every patient in your practice? ☐ Yes ☐ No **If Yes, attach a copy of the health history form used in your practice.** If No, please explain: ____________________

25. Are you on staff, or affiliated in any way with a hospital or clinic? ☐ Yes ☐ No If Yes, Complete the following:

Institution: ____________________ Days Per Week: ________

Address: ____________________ City: ____________ State: ________ Zip Code: ________

Does the hospital or clinic provide you with malpractice insurance? ☐ Yes ☐ No

26. **DENTAL SCHOOL FACULTY - PREMIUM CREDIT**

Faculty of duly accredited dental schools are afforded premium credits. If you are a faculty member of such an institution, complete this section. **PLEASE SUBMIT A COPY OF YOUR CURRENT LETTER OF APPOINTMENT.**

Name of Dental School: ____________________ Telephone No.: (   )

On Faculty Since ________ Position/Department ____________________

Days of the Week ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Hours Per Day ____ ____ ____ ____ ____ ____ ____

INSURANCE HISTORY AND CLAIMS

27. Insurance Coverage Summary For The Past Four (4) Years

Insurer	Policy Number	Policy Term	Limits of Insurance	Premium	Claims Made or Occurrence

28.

Note: Missouri applicants, do not respond.

Has any insurance company ever declined coverage, refused to renew, conditionally renewed or canceled a professional liability policy covering you? ☐ Yes ☐ No If Yes, please list:

a) The Company: ____________________

b) The date: ____________________

c) The reason for the Company's action: ____________________

29.	Have you ever been the subject of an investigatory or disciplinary proceeding or review? ☐ Yes ☐ No
30.	Have you ever been placed on probation? ☐ Yes ☐ No
31.	Have you ever had your dental license suspended or revoked? ☐ Yes ☐ No Have you ever had your license to issue prescription drugs suspended or revoked? ☐ Yes ☐ No
32.	Have you ever been convicted of a crime (other than a minor traffic offense) or do you have any crimina chargel pending against you? ☐ Yes ☐ No
33.	Are you presently being treated for alcoholism, drug addiction or other substance ☐ Yes ☐ No
34.	During the past five (5) years, have you been under the care of a physician? ☐ Yes ☐ No If Yes, describe why treatment was sought, current status, and date of last visit. ________
35	Have you ever been denied membership or participation in any health maintenance or similar organization? ☐ Yes ☐ No
	IF THE ANSWER TO ANY OF QUESTIONS 28 - 35 IS YES, PLEASE ATTACH A DETAILED EXPLANATION, PHYSICIANS STATEMENT AND/OR COPIES OF ANY OFFICIAL ORDERS OR STIPULATIONS.
36.	**CLAIM/INCIDENT HISTORY** a) Have you ever had a malpractice claim or suit filed against you? ☐ Yes ☐ No b) Has there ever been a malpractice claim or suit filed against your corporation/partnership/association? ☐ Yes ☐ No c) Do you know of any incident which may result in a claim against you, your partners, or any members of corporation/organization? ☐ Yes ☐ No d) Have you ever received a request for records by a patient's attorney? ☐ Yes ☐ No IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, COMPLETE AND ATTACH A **SUPPLEMENTAL** CLAIM INFORMATION FORM FOR EACH CLAIM, SUIT, OR INCIDENT.

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND 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 FINES AND CONFINEMENT IN PRISON.

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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

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 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.

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 A 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 YORK APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS 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 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 ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

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 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.

NOTICE TO TENNESSEE AND 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.

REPRESENTATIONS

By signing this application you, the applicant, agree with us, the Company, that:

a. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have divulged any and all such situations in Question 36 of this application; and

b. The application and attachments, and all of the statements and answers given therein are:

1. accurate and complete to the best of your knowledge;
2. representations you are making on behalf of all persons and entities proposed to be covered;
3. a material inducement to us to provide a proposal for insurance and any policy issued by us is issued in specific reliance upon these representations; and
4. attached to, incorporated into, and form a part of this policy.

c. You agree to report to us in writing any material change in your operations, conditions, or answers provided in this application that may occur or be discovered after the completion date of the application and before the effective date of the policy. On receipt of such written notice, we have the right to modify or withdraw any proposal for insurance we have offered, at our sole discretion.

d. You authorize us, our agents and representatives to secure claims information from your current and previous insurance carriers.

e. The discovery of any fraud, intentional concealment, or misrepresentation of material fact will render this Policy, if issued, void at inception.

f. If this application is for Claims Made coverage, only claims first made against you and reported to us during the policy period or any applicable extended reporting period are covered, subject to the policy provisions.

SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and [NY: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

Signing of the application does not bind you or us.

Signature of Applicant _______________ Date _______________

Bryan Lau, CPA

PO Box 3436

Laurel, MD 20709

bryanlau@lau2.com

301-470-6126

Fax 301-470-3634

Owners must submit current Certificate of Insurance for all dentist employees and Independent Contractors.

86025 (6/04)

SUPPLEMENTAL CLAIM INFORMATION

Please complete if you answered "Yes" to any part of Question 36. Complete one form for each claim, suit, or incident. If additional space is needed, attach a separate sheet.

Applicant Name ______________________________

Name of Claimant or Plaintiff ______________________________

Other Claimant Data: Age: __________ Sex: __________ Marital Status: __________

Date of Actual or Alleged ______________________________
Location of Incident: ☐ Office ☐ Clinic ☐ Hospital ☐ Other: __________

Was incident reported to your insurance carrier? ☐ Yes ☐ No
If yes, please provide date of the report: __________ and a copy of the report, if in writing.

Narrative Description of Incident. Describe the type of treatment rendered, as well as the injuries for which the claim was made. If the claim was not made by a patient, describe how it arose. (Include claimant's social security number if available.)

____

List any other dentists or physicians who provided treatment prior or subsequent to the claim:

____

List any other parties, institutions or hospitals involved as codefendants.

____

Name of the insurance company defending you, if applicable: __________

Current Status of the Claim/Suit ☐ Formal suit actually brought against you ☐ Suit merely threatened ☐ Claim limited to attorney contact ☐ Incident only

Disposition of Claim ☐ Abandoned (No activity in 3 years) ☐ Dismissed by the court ☐ Verdict won by defense ☐ Judgment against codefendants only ☐ Settled for plaintiff ☐ Verdict won by plaintiff

If settled for or won by plaintiff, state amount paid on your behalf and date of payment: __________

If claim is open, state the amount or value of the claim (if known): __________

86025 (6/04)

What have you done to prevent a similar incident or claim from happening again?

If not already described above, please describe any other incidents or adverse results that may develop into future claims or suits, including licensing board or peer review committee proceedings.

SIGNATURE

Signing this form indicates that the information provided above is true to the best of your knowledge and belief.

Signature of Applicant Date