

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 your 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.

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

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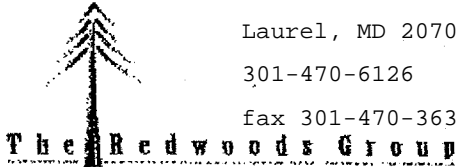
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**NATIONAL UNION FIRE INSURANCE COMPANY
OF PITTSBURGH, P.A**

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: _____		<input type="checkbox"/> Male
		<input type="checkbox"/> 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

_____	Professional Degree	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 many 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 No
 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30.	Have you ever been placed on probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31.	Have you ever had your dental license suspended or revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had your license to issue prescription drugs suspended or revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32.	Have you ever been convicted of a crime (other than a minor traffic offense) or do you have any criminal charges pending against you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
33.	Are you presently being treated for alcoholism, drug addiction or other substance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34.	During the past five (5) years, have you been under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b)	Has there ever been a malpractice claim or suit filed against your corporation/partnership/association?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c)	Do you know of any incident which may result in a claim against you, your partners, or any members of corporation/organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d)	Have you ever received a request for records by a patient's attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 FRAUD 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 FRAUDULATING OR ATTEMPTING TO FRAUD 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 FRAUDULATING OR ATTEMPTING TO FRAUD 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.

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