MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.
a Berkshire Hathaway Company

WASHINGTON DENTAL INDIVIDUAL APPLICATION

Mikel's
INSURANCE SERVICES
Authorized Agency

FAX Application to: 562-928-8149
or
Email: rwalton@mikels-ins.com

Questions call 800-928-0431 Ext. 128

(Please provide a copy of your current Certificate of Liability)

*If previously insured with Medical Protective, please provide the policy number.

Policy # _____

www.MedProDentist.com

DENTAL INDIVIDUAL APPLICATION

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I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Last Name _____ First Name _____ M.I. _____ Suffix _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number (Optional) _____

National Provider Identifier (NPI) _____

E-Mail _____

Business Fax _____ Business Phone _____ Residence/Cell Phone _____

B. Practice Location(s):
(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice _____ Type of Location: ☐ Hospital ☐ Office ☐ Residence

Location Name _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

2. Additional Location:

% of Practice _____ Type of Location: ☐ Hospital ☐ Office ☐ Residence

Location Name _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

C. Preferred Billing and Correspondence Address:

☐ Location Number (From Section B. above) _____ ☐ Other (please enter below)

Number and Street _____ Suite _____

City _____ State _____ Zip Code _____

II. EDUCATIONAL BACKGROUND

A. Are you entering private practice for the first time? ☐ Yes ☐ No

B. Have you completed a risk management education course within the last twelve (12) months? ☐ Yes ☐ No

If you answered yes, did the course provide **all** of the following? ☐ Yes ☐ No

1. A minimum of three continuing dental education (CDE) hours;
2. Sponsored by an approved national/regional dental education sponsor; and
3. Strictly adheres to a risk management (loss prevention) curriculum

C. Dental School:

Name of School _____

City _____ State _____ Country _____

Degree _____ Completed From (MM/YYYY) _____ To (MM/YYYY) _____

II. EDUCATIONAL BACKGROUND (CONTINUED)

D. Residency:

(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, etc.)
(If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? ☐ Yes ☐ No ☐ Still in Training From (MM/YYYY) _____ To (MM/YYYY) _____

2. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? ☐ Yes ☐ No ☐ Still in Training From (MM/YYYY) _____ To (MM/YYYY) _____

III. PRACTICE INFORMATION

A. States in which you hold a license to practice dentistry:
Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

		Active	Inactive	Temporary	Pending
1.	State _____ License # _____	☐	☐	☐	☐
2.	State _____ License # _____	☐	☐	☐	☐

3. DEA License? ☐ Yes ☐ No

B. Please indicate your earliest start date at your current location(s): (MM/YYYY) _____

C. Do you have previous practice locations? ☐ Yes ☐ No

If yes, list most recent location first dating back within the past ten years.

1. Name of Practice _____

City _____ State _____ Country _____

Specialty _____ From (MM/YYYY) _____ To (MM/YYYY) _____

2. Name of Practice _____

City _____ State _____ Country _____

Specialty _____ From (MM/YYYY) _____ To (MM/YYYY) _____

D. In the past ten years, please explain any gaps greater than one year between practice locations. _____

_____

E. To which dental societies or associations do you belong? _____

_____

F. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage: (If none, please enter '0' in the space provided.)

Patients Per Week _____ Hours Per Week _____ Unscheduled New Walk-In Patients Per Week _____

IV. RATING INFORMATION

A. Please check your present specialty:

- ☐ General Dentist
- ☐ Orthodontist
- ☐ Pediatric Dentist
- ☐ Endodontist
- ☐ Periodontist
- ☐ Prosthodontist
- ☐ Oral Pathologist
- ☐ Dental Anesthesiologist
- ☐ Pain Management (Please explain) _____
- ☐ Other (Please explain) _____
- ☐ Oral & Maxillofacial Surgeon
  - ☐ Dual Degree
  - ☐ Board Certified
    - Date of Certification (MM/YYYY) _____

B. Please check procedures you will perform in your practice:

- ☐ **Orthodontic Full Mouth Banding**
  Year you began this procedure (YYYY) _____
- ☐ **Placement of Mini Implants for Orthodontic/Prosthesis**
- ☐ **Implant Prosthesis/Supported Prosthesis**
- ☐ **Sargenti Root Canal Method Utilizing N2 or Similar Paste**
- ☐ **Surgical Placement of Implant Fixtures**
  Year you began this procedure (YYYY) _____
- ☐ **Botox, Dermal Fillers (i.e. Injections)**
- ☐ **Cosmetic Full Mouth Rehabilitation**
- ☐ **Alternative (Holistic) Dentistry/Medicine**
  Please explain _____
- ☐ **Sleep Apnea Therapy**
  Do you treat only after a physician referral? ☐ Yes ☐ No
- ☐ **Obesity/Weight Control Treatment**

Third Molar Extractions (CPT/CDT Codes)

- ☐ **Erupted (D7110, D7120, D7210)**
  Year you began this procedure (YYYY) _____
- ☐ **Partially Impacted (D7220, D7230)**
  Year you began this procedure (YYYY) _____
- ☐ **Fully Impacted (D7240, D7241, D7250)**
  Year you began this procedure (YYYY) _____

- ☐ **Sinus Lifts**
- ☐ **Palatal Inserts**
  Do you treat only after a physician referral? ☐ Yes ☐ No
- ☐ **Nerve Grafts**
- ☐ **Cleft Lip and Palate Surgery**
- ☐ **Face Lifts**
- ☐ **Management of Malignant Lesions**
- ☐ **Orthognathic Surgery**
- ☐ **Rhinoplasty**
- ☐ **Skin Peels**
- ☐ **Spa Services**
  Please explain _____
- ☐ **TMJ Services**
  - ☐ **Arthroscopy**
  - ☐ **Implant**
  - ☐ **Reconstruction**
- ☐ **Trigger Point Injections**
- ☐ **Other**
  Please explain _____

C. Indicate the percentage of your practice devoted to the following procedures:
(Total does not have to equal 100%)

_____ % Denture Procedures ☐ Same Day or Economy ☐ Replacement ☐ Relines

_____ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)

_____ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)

_____ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)

_____ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

D. Please indicate which procedures you perform and whether you obtain informed consent and have received training for each of the procedures selected.

	Informed Consent Type			Training		
☐ Orthodontic Full Mouth Banding	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Surgical Placement of Implant Fixtures	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Partially Impacted Third Molar Extractions	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Fully Impacted Third Molar Extractions	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Nitrous Oxide Analgesia	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Conscious Sedation	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ General Anesthesia/Unconscious Sedation	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Facial Surgery	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Botox, Dermal Fillers (i.e. Injections)	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Other (Please explain) _____	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None

E. Have you discontinued any procedures listed in B. or C. above? ☐ Yes ☐ No

Which procedures? _____ When? (MM/DD/YYYY) _____

V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

☐ *Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242* - (excluding nitrous oxide) 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.

☐ IM/IV ☐ Oral

☐ *General Anesthesia Utilizing CPT/CDT Code D09220-* (to include deep sedation) 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 purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.

B. ☐ **Please "X" here if this section *does not* apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.**

VI. ADDITIONAL PROFESSIONAL INFORMATION

A. Do you treat non-federal prison inmates? ☐ Yes ☐ No
If yes, what percentage of your practice is devoted to treating non-federal inmates? _____ %

B. Do you treat or review treatment of federal prison inmates? ☐ Yes ☐ No
If yes, please explain _____
(If you are covered by other insurance for the activities in A or B of this section, please complete Section VI, Question J.)

C. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No
If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

D. Has any professional liability insurance company ever declined, refused, cancelled, or non-renewed your coverage, or have you ever had an involuntary deductible or surcharge assessed against your policy? ☐ Yes ☐ No
If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

E. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No
If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

F. Have you ever incurred or become aware of having a condition that impairs your ability to practice your dental specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.) ☐ Yes ☐ No

If yes, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type(s) of Illness _____
Date(s) of Treatment(s): From (MM/YYYY) _____ To (MM/YYYY) _____
Treating Physician(s): Name(s) _____ Address(es) _____

G. Do you use a collection agency which has the authority to file collection suits without your knowledge? ☐ Yes ☐ No

H. Is the standard of care altered based on the patient's, custodial parent's or legal guardian's ability to pay? ☐ Yes ☐ No

I. Are you affiliated with a group that has more than three active locations? ☐ Yes ☐ No

J. Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, are you an: ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice Name _____
Location _____
Name of Insurer _____

K. Are you affiliated with a management service organization or dental practice franchise? ☐ Yes ☐ No

VII. PRACTICE ORGANIZATION INFORMATION

Please check boxes that best describe your practice affiliation(s).

A. Employment Status:

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed (MM/DD/YYYY) _____

B. Entity / Organization Type: (You must check at least one box.)

☐ Solo Unincorporated/Sole Proprietor
☐ Solo Incorporated
☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company
☐ Licensed Dental Surgery Center
☐ Clinic Receives Governmental Immunity
☐ Other (Please explain) _____

☐ Mobile Dental Practice
☐ Nursing Home Based Practice
☐ Dental School - Faculty
☐ Clinical supervision of students
Hours per week _____
☐ Dental Students/Residents

C. Name all of your affiliated professional corporations or associations (including DBA's and Individual Dentists):

_____

D. Is this entity or employer currently insured with The Medical Protective Company? ☐ Yes ☐ No

If yes, please provide The Medical Protective Company individual, corporation or partnership policy and group number, if known.

Policy # _____ Group # _____

E. Do you desire coverage for this entity? ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

☐ **Shared Limit -** Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.

☐ **Separate Limit -** Available for all Entity/Organization Types. A separate entity application is required.

To request separate entity coverage, please contact your agent or Med Pro customer service (800-4MedPro) to complete an entity application for consideration.

VIII. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been involved in a claim or suit arising out of the rendering or failure to render professional services? ☐ Yes ☐ No

If **yes**, how many?_____

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes but is not limited to the following: ☐ Yes ☐ No

-Cancer -Death -Permanent Neurological Injury -Permanent Nerve Injury

If **yes**, how many?_____

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you? ☐ Yes ☐ No

If **yes**, how many?_____

IX. COVERAGE INFORMATION

A. Coverage Desired:

- ☐ Occurrence
- ☐ Claims-Made coverage without Prior Acts coverage
- ☐ Claims-Made coverage with Prior Acts coverage
- ☐ Convertible Claims-Made coverage with Prior Acts coverage

B. Requested Coverage Effective Date:

From (MM/DD/YYYY) _____ 12:01 a.m. To (MM/DD/YYYY) _____ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) _____ 12:01 a.m.

(This date is not required for Occurrence or Claims-Made without Prior Acts policies)

D. List all previous professional liability insurers in the last ten years:

1. Current Insurer _____ Current Premium _____

   ☐ Occurrence ☐ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

2. Previous Insurer: _____

   ☐ Occurrence ☐ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

3. Previous Insurer: _____

   ☐ Occurrence ☐ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

E. Please explain any gaps in coverage in the past ten years. _____

F. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- ☐ An extended reporting endorsement (tail coverage) has been purchased.
- ☐ An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with The Medical Protective Company, if offered, will not provide prior acts coverage.

☐ **Initial Here**

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".

G. Limits Desired: _____ Per Occurrence/Per Claim Made _____ Annual Aggregate

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? ☐ Yes ☐ No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

☐ **Initial Here**

Name _____

Number and Street _____ Suite _____

City _____ State _____ Zip _____ Phone Number _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

XI. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

Please initial the statements below.

Mandatory: All applicants must read and initial the following:

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.

Initial Here

XII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments**") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature _____ Date Signed _____

Type or Print Name _____

XIII. ADDITIONAL INFORMATION

Attach a separate piece of paper if additional space is needed.