

B. RESIDENCY, FELLOWSHIP OR UNIVERSITY/CLINICAL BASED TRAINING: LIST ALL TRAINING LOCATIONS. (continued)

(i.e., Residency Specialty Training, Anesthesia Residency Training, Fellowship, GPR, AEGD Military Rotation, etc.)

2.

NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM - TO -

MM YYYY MM YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., Other Than Residency or Fellowship) YES NO

1.

NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM - TO -

MM YYYY MM YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN 6 MONTHS BETWEEN YOUR DENTAL SCHOOL, RESIDENCY, FELLOWSHIP OR FIRST TIME IN PRIVATE PRACTICE: _____

E. IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE:

- -

MM DD YYYY

(Your Medical Protective Company policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.)

F. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? YES NO

G. HAVE YOU PARTICIPATED IN ANY CONTINUING DENTAL EDUCATION WITHIN THE LAST TWO YEARS? YES NO

If yes, how many credit hours?

H. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE LAST TWELVE (12) MONTHS? YES NO

I. IF YOU ANSWERED YES, DID THE COURSE PROVIDE ALL OF THE FOLLOWING: YES NO

- A minimum of three continuing dental education (CDE) HOURS?
- Sponsored by an approved national/regional Dental Educational sponsor, and strictly adhere to a risk management (loss prevention) curriculum?
- Are the CDE hours through an approved regional dental sponsor?

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER DENTISTS OR ORGANIZATIONS WHO RENDER DENTAL/MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE?

YES NO

(If this is covered by another professional liability insurance policy, complete question 9 in section VII.)

If Yes, Which State(S):

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE DENTISTRY:

(Exclude state abbreviation)

Please check the appropriate box to indicate the status of your license

1. STATE LICENSE #
2. STATE LICENSE #
3. STATE LICENSE #

Active Inactive Temporary Pending
[] [] [] []
[] [] [] []
[] [] [] []

4. DEA LICENSE? YES NO If no DEA License, why?

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING

If no previous location(s), please indicate your earliest start date at your current location(s): MM - YYYY

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

3. NAME OF PRACTICE
CITY STATE COUNTRY
SPECIALTY FROM MM - YYYY TO MM - YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN ONE MONTH BETWEEN PRACTICE LOCATIONS:

E. TO WHICH STATE/LOCAL DENTAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG?

If none, please explain:

IV. RATING INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. WHAT IS YOUR PRESENT SPECIALTY?

- | | | | |
|--------------------------------------------|--------------------------------------------------|------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> General Dentist | <input type="checkbox"/> Periodontist | <input type="checkbox"/> Oral & Maxillofacial Surgeon | <input type="checkbox"/> Board Certified? (Date): |
| <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Prosthodontist | <input type="checkbox"/> Dual Degree (Dental/Medical) | MM - YYYY |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Oral Pathologist | <input type="checkbox"/> Pain Management (Please explain): | Type: _____ |
| <input type="checkbox"/> Endodontist | <input type="checkbox"/> Dental Anesthesiologist | <input type="checkbox"/> Other: | _____ |

B. PLEASE INDICATE THE AVERAGE WEEKLY HOURS OR PATIENTS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE. (If you practice in multiple states, please identify the following information for each state.)

PATIENTS SEEN PER WEEK [] [] [] [] HOURS PER WEEK [] [] [] [] NEW WALK-IN PATIENTS PER WEEK [] [] []

C. PLEASE CHECK PROCEDURES YOU CURRENTLY OR WILL PERFORM IN YOUR PRACTICE: (Please check all that apply)

- | | |
|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Orthodontic Full Mouth Banding
Year you began these procedures: [] [] [] []
YYYY | <input type="checkbox"/> Third Molar Extractions (CPT/CDT Codes)
<input type="checkbox"/> Erupted (D7110, D7120)
Year you began these procedures: [] [] [] []
YYYY |
| <input type="checkbox"/> Surgical/Anchor portion of Dental Implants
Year you began these procedures: [] [] [] []
YYYY | <input type="checkbox"/> Partial Impaction (D7210, D7220, D7230)
Year you began these procedures: [] [] [] []
YYYY |
| <input type="checkbox"/> Prosthesis/Abutment
Year you began these procedures: [] [] [] []
YYYY | <input type="checkbox"/> Fully Impacted (D7240, D7241, D7250)
Year you began these procedures: [] [] [] []
YYYY |

IMPLANT TYPE:

- | | | |
|------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Endosteal | <input type="checkbox"/> Mini Implants | <input type="checkbox"/> Subperiosteal |
| <input type="checkbox"/> Mandibular Multi-quadrant - Ramus Frame | <input type="checkbox"/> Other Implant Types: _____ | |

Sargenti Root Canal method utilizing N2 or similar paste.

Sleep Apnea Therapy

Do you treat only after physician referral? YES NO

Molar Endodontics

- | | | |
|------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Nerve Grafts | <input type="checkbox"/> Face Lifts | <input type="checkbox"/> Alternative (holistic) Dentistry/Medicine
Please Explain: _____ |
| <input type="checkbox"/> Sinus Lifts | <input type="checkbox"/> Skin Peels | _____ |
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Cleft Lip and Palate Surgery | <input type="checkbox"/> Spa Services
Please Explain: _____ |
| <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Rhinoplasty | _____ |
| <input type="checkbox"/> Bleaching/Whitening agents | <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Obesity/Weight Control Treatment
Please Explain: _____ |
| <input type="checkbox"/> Permanent Eye Liner/Lip Tattooing | <input type="checkbox"/> TMJ Arthroscopy | _____ |
| <input type="checkbox"/> Parotid Gland Surgery | <input type="checkbox"/> Vitec Implant | |
| <input type="checkbox"/> Management of Malignant Lesions | <input type="checkbox"/> TMJ Implants | |
| <input type="checkbox"/> Orthognathic Surgery | <input type="checkbox"/> Reconstructive Surgery | |

Other Dental Techniques that will help

Medical Protective better understand any special circumstances concerning your practice

List Procedures: _____

D. INDICATE THE PERCENT OF YOUR PRACTICE DEVOTED TO THE FOLLOWING PROCEDURES: (Does Not have to equal 100%)

- [] [] [] % Dentures Including: (check all that apply): Same Day or Economy Dentures Replacement Dentures Denture Relines
- [] [] [] % Oral Surgery (extractions, removal of cysts, etc)
- [] [] [] % Elective facial cosmetic surgery/procedures (including rhinoplasty, face-lifts, skin grafts, botox, collagen, etc.)
- [] [] [] % Reconstructive Cosmetic Procedures (i.e., cancerous lesion, facial reconstruction, cleft lip/palate, etc)
- [] [] [] % Procedures performed outside of the Oral and Maxillofacial Region (except bone harvesting procedures).

Please explain: _____

IV. RATING INFORMATION (continued)

If Additional Space is Needed, Please Use Supplemental Form

E. HAVE YOU DISCONTINUED ANY PROCEDURES?

YES NO

Which procedure(s)? _____

When:

--	--

 -

--	--	--	--

 MM YYYY Why? _____

F. HAVE YOU ADDED ANY NEW SERVICES, PROCEDURES OR TREATMENTS TO YOUR PRACTICE IN THE LAST 12 (TWELVE) MONTHS?

YES NO

Which procedure(s)? _____

When:

--	--

 -

--	--	--	--

 MM YYYY Why? _____

G. EXCEPT FOR ANESTHESIA PROCEDURES REFERRED TO DENTAL ANESTHESIOLOGISTS OR PROCEDURES REFERRED BY SPECIALISTS BACK TO THE PRIMARY DENTAL CARE PROVIDER, DO YOU:

1. Refer patients to other dentists that are not licensed as dental "specialists" for the procedures being performed?

YES NO

If yes, are the procedures performed in your office?

YES NO

If no, where: _____

Please list the procedures referred to non-specialists: _____

2. If you are **not** licensed as a dental specialist, do you accept referrals from other dentists?

YES NO

If yes, are the procedures performed in your office?

YES NO

If no, where: _____

Please list the procedures referred to you: _____

V. BUSINESS PRACTICES

If Additional Space is Needed, Please Use Supplemental Form

A. PLEASE INDICATE WITH AN (X) EACH OF THE PROCEDURES YOU PERFORM, TRAINING AND WHETHER YOU OBTAIN INFORMED CONSENT FOR EACH OF THE PROCEDURES YOU CHECKED

	<i>Do you obtain informed consent?</i>	<i>40 CE's</i>	<i>Residency</i>	<i>None</i>
<input type="checkbox"/> Full Mouth Banding Orthodontics	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> Dental Implants (Anchor portion only)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> Partial Impacted Third Molar Extractions	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> Fully Impacted Third Molar Extractions	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> General Anesthesia Sedation	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> Facial Cosmetic Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> Other (Please Explain): _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Residencies must be documented in Section II. (Educational Background)

I do not perform these procedures

B. IF YOU ANSWERED "NONE" TO THE CONTINUING EDUCATION QUESTIONS, PLEASE EXPLAIN YOUR ADDITIONAL EXPERIENCE FOR EACH PROCEDURE YOU PERFORM:

VI. ANESTHESIA INFORMATION (continued)

If Additional Space Is Needed, Please Use Supplemental Form

K. DO YOU UTILIZE THE FOLLOWING EQUIPMENT: (Please "X" equipment used) *If you are a host Dentist please verify whether you or any anesthesia provider utilized outside of a hospital setting will supply the following equipment:*

(Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital setting)

- | | | |
|----------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Fail safe mechanisms on anesthesia machines | <input type="checkbox"/> Sphygmomanometer/Stethoscope | <input type="checkbox"/> Portable Suction |
| <input type="checkbox"/> Basic Airway Equipment | <input type="checkbox"/> Electrocardiographic Monitoring Equipment | <input type="checkbox"/> Capnography |
| <input type="checkbox"/> Full Face Mask Resuscitator | <input type="checkbox"/> Pulse Oximeter | <input type="checkbox"/> Auxiliary Lighting |
| <input type="checkbox"/> Oral and Nasopharyngeal Airways | <input type="checkbox"/> CO2 Monitor | <input type="checkbox"/> Emergency Pharmaceutical Kit |
| <input type="checkbox"/> Endotracheal Tubes (Adult/Child size) | <input type="checkbox"/> Internal/External Temperature Monitor | <input type="checkbox"/> Direct Current Defibrillator |
| <input type="checkbox"/> Laryngoscope | <input type="checkbox"/> Tracheostomy/Coniotomy Equipment | |

L. IF YOU ARE A HOST DENTIST, HAVE YOU AND WILL YOU ENSURE THAT ALL ANESTHESIA PROVIDERS PROVIDING SERVICES TO YOUR PATIENTS HAVE:

- The equipment you indicated above? YES NO
- Ensure the provider has a minimum of a two year anesthesia residency? YES NO
- If your anesthesia provider is a CRNA, are they supervised on site by a doctor with a minimum two year anesthesia residency or greater? YES NO
- Professional liability limits equal to or greater than your policy limits? YES NO
- A valid license in your state of practice? YES NO

VII. ADDITIONAL PROFESSIONAL INFORMATION

If Additional Space Is Needed, Please Use Supplemental Form

(If you are covered by other insurance for this activity, please complete section VII. Question 9.)

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM

1. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? YES NO

If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.
(If you are covered by other insurance for this activity, please complete section VII. Question 9.)

2. Do you treat or review treatment of federal prison inmates? YES NO

If yes, please explain: _____

(If you are covered by other insurance for this activity, please complete section VII. Question 9.)

3. Do you treat non-federal prison inmates? YES NO

If yes, what percentage of your practice is devoted to treating non-federal prison inmates? %
 Does this facility have a law library? YES NO
(If you are covered by other insurance for this activity, please complete section VII. Question 9.)

4. Do you use a collection agency which has the authority to file collection suits without your knowledge? YES NO

If yes, please explain: _____

5. Have you had involvement in the design, manufacture or distribution of any dental product(s) or written an instruction manual for products for use by other dentists? YES NO

If yes, please explain and indicate the date(s): _____ Date: -

(The professional liability coverage you are applying for does not provide product liability coverage.)
 MM YYYY

Do you have separate coverage for this product liability exposure? YES NO

6. 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 Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? YES NO

If yes, please explain and indicate the date(s): _____ Date: -

 MM YYYY

7. Have you had any professional liability insurance declined, refused, canceled or non-renewed? YES NO

If yes, please indicate the reason and date(s): _____ Date: -

 MM YYYY

VII. ADDITIONAL PROFESSIONAL INFORMATION (continued)

If Additional Space is Needed, Please Use Supplemental Form

(If you are covered by other insurance for this activity, please complete section VII. Question 9.) (continued)

8. Have you incurred or become aware of having a condition that impairs or could impair your ability to practice your dental profession?

YES NO

(e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)

If **Yes**, please state the condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **a statement from your treating 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 of Illness: _____

Duration of Illness: - To -
MM YYYY MM YYYY

Treating Physician (Name & Address): _____

9. Will you be performing activities which will be covered by another professional liability policy?

YES NO

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

Practice name and location(s): _____

Name of Carrier: _____

10. Do you adhere to The Americans with Disabilities Act and treat patients with disabilities, including patients with HIV/AIDS?

YES NO

VIII. PRACTICE ORGANIZATION INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PRACTICE ORGANIZATION:

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

Solo Unincorporated/Sole Proprietor

 Entity Name:

Employment Status

Sole Proprietor Employee Shareholder/Partner Independent Contractor Other Date Joined/Formed: -
MM YYYY

If Other, please explain: _____

Solo Incorporated-No employed or contracted dentists

 Entity Name

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/Formed: -
MM YYYY

If Other, please explain: _____

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 #: Sub-Group#:

If no, do you desire coverage for this entity?

YES NO

If yes, do you have any employed or contracted dentist associated with your practice?

YES (1) NO

If no, do you wish to share your individual policy limits with your solo corporation?

YES NO

If yes, and you desire to share your individual policy limits, please initial here:

Note: To qualify for shared limit solo corporation coverage, you must have no dentists employees or dentists independent contractors.

** If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate entity application for consideration. **

A. PRACTICE ORGANIZATION: (continued)

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

Multi-Shareholder Corporation, Partnership, Limited Liability Company

Entity Name: _____

Employment Status

Employee Shareholder/Partner Independent Contractor Other

Date Joined/Formatted: MM - YYYY

If Other, please explain: _____

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: _____ Group #: _____ Sub-Group#: _____

If no, do you desire coverage for this entity? YES (1) NO

Management Services Organization Dental Director

Entity Name: _____

Employment Status

Employee Shareholder/Partner Independent Contractor Other

Date Joined/Formatted: MM - YYYY

If Other, please explain: _____

Does the entity provide Allied staff? YES NO

Is the entity responsible for billing practice fees? YES NO

Is the entity responsible for setting office protocols and referral standards? YES NO

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: _____ Group #: _____ Sub-Group#: _____

If no, do you desire coverage for this entity? YES (1) NO

Hospital Industrial Government-Branch: _____

Entity Name: _____

Employment Status

Employee Shareholder/Partner Independent Contractor Other

Date Joined/Formatted: MM - YYYY

If Other, please explain: _____

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: _____ Group #: _____ Sub-Group#: _____

If no, do you desire coverage for this entity? YES (1) NO

X. CLAIMS/SUIT INFORMATION FORM

(Please make copies if additional forms are needed)

If making additional copies, please enter applicant's name here: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION

1. Patient/Claimant Information:

LAST NAME

FIRST NAME

AGE: Gender: Male Female

2. Date of treatment and/or surgery, which led to the allegations against you. -
MM YYYY

3. Date claim/incident notice received. -
MM YYYY

4. Date claim reported to prior insurer -
MM YYYY

5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: _____

6. Disposition or current status of claim or suit: OPEN CLOSED

If Closed, Date of Closing/Settlement or award: -
MM YYYY

7. Indicate case value established by carrier, if known: \$, ,

8. Defending Insurance carrier name: _____
CARRIER NAME

9. Claim file number, if known: _____
CLAIM NUMBER

10. Was this matter closed with your consent? YES NO

Was a suit filed? YES NO

Was payment made? YES NO

If no, was claim or suit withdrawn? YES NO

If yes, indicate total amount of settlement or award: \$, ,

Amount paid on your behalf: \$, ,

11. Nature of allegations in the claim or suit:

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

12. Please provide a narrative description of the medical/dental facts:

(must include, but not limited to the type of treatment and/or surgery; your involvement): _____

XI. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. List all previous professional liability insurers, dating back to completion date of formal training.

LIST CURRENT INSURER FIRST

1.		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY to MM - DD - YYYY
2.		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY to MM - DD - YYYY
3.		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY to MM - DD - YYYY

Please explain any gaps in coverage back to your start date of practice: _____

B. COVERAGE DESIRED

1. Occurrence
2. Claims-Made Coverage without Prior Acts Coverage
3. Claims-Made Coverage with Prior Acts Coverage *(A copy of current declaration page showing current retroactive date must be attached)*
4. Convertible Claims-Made with Prior Acts Coverage

If 1 or 2 are selected from the above 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 (copy of tail is attached)
- An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, 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 an "extension contract" or "tail coverage."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.

This date cannot be earlier than the expiration date of your current policy.

From: MM - DD - YYYY 12:01 a.m.

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

To: MM - DD - YYYY 12:01 a.m.

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:
(NOT REQUIRED FOR OCCURRENCE POLICIES OR CLAIMS-MADE WITHOUT PRIOR ACTS)

MM - DD - YYYY 12:01 a.m.

E. Limits Desired: [] , [] , [] per occurrence/per claims-made
 [] , [] , [] annual aggregate

Note: Requested limits may not be available from this company

F. The EPLI Retroactive Date shown on my current Claims Made policy is:
This date cannot be greater than the retroactive date shown on your current policy

MM - DD - YYYY 12:01 a.m.

XII. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my: Employer OR Named Third Party (Include Name&Address) _____

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc). 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

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

XIII. STATE STATUTORY REQUIREMENT

NOTE: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

XIV. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application 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, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, 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.

Date Signed: - -
MM DD YYYY

Signature

Print Name

When would you like your quote delivered? - -
MM DD YYYY

