PHYSICIANS' RECIPROCAL INSURERS
1800 Northern Boulevard
P.O. Box 9007
Roslyn, NY 11576

(516) 365-2855
Toll Free: (888) 526-4006

"THE EXCHANGE"

APPLICATION

FOR DDS/DMD INDIVIDUAL PROFESSIONAL LIABILITY COVERAGE

IMPORTANT INSTRUCTIONS

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY

PLEASE PRINT or TYPE all information and make sure all questions are answered in full. Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.

If you have had claims or suits filed against you please make certain you have completed a claims information form for each claim or suit in the past 10 years.

Be sure to use REMARKS section for all required additional information.

Upon acceptance of your application you will be notified of premium due. Upon payment of the premium, your policy will become effective.

ADDENDUM TO DECLARATIONS PAGE
AND THE APPLICATION FORM

NOTICE

If this policy is written on a claims-made basis:

This policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the initial coverage date stated in the policy.

This policy covers claims actually made against the insured and incidents reported while the policy remains in effect and all coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases additional unlimited extended reporting period coverage.

The rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage and such rate may be subject to substantial increase over the rates currently in effect. The average statewide percentage changes, and the effective dates of each rate revision which Physicians' Reciprocal Insurers has implemented in this State during the five (5) year period immediately preceding the effective date of the policy, will be provided upon the written request of the insured. Such past changes may or may not be indicative of future rate changes.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims made or incidents reported after such period of sixty (60) days.

During the first few years of coverage under a claims-made policy, the annual rate is comparatively lower than occurrence rates issued by any insurer, however, such annual rate increases significantly in all companies, independent of overall rate level increases, until the claims-made relationship reaches maturity.

1. Full Name: ______________________________ Date of Birth: ______________

Home Address: ____
Number & Street City State Zip

2. Location(s) at which practice is conducted:

______________________________ Hours/Week: ______
Number & Street City State Zip

______________________________ Hours/Week: ______
Number & Street City State Zip

______________________________ Hours/Week: ______
Number & Street City State Zip

______________________________ Hours/Week: ______
Number & Street City State Zip

______________________________ Hours/Week: ______
Number & Street City State Zip

______________________________ Hours/Week: ______
Number & Street City State Zip

3. Home Phone: ______________________ Office Phone: ______________________

4. I wish to have all correspondence sent to: Home: __________Primary Office _______ Other (specify below)_____

____

5. E-Mail Address: ___________________________________ Website: _______________________________________

6. Dental School Attended: ____ Year Graduated: ______________

Additional Training: ____

Professional Designation: DDS ____________ DMD __________

7. License Number: _________________________________ Years in Practice: _____________________

8. Non-New York State Dental Licenses:

State: ___________________________ License Number: _______________________ Date Issued: ___________

State: ___________________________ License Number: _______________________ Date Issued: ___________

9. Social Security Number: _____________________________________ I.R.S. Tax ID Number: __________________

POLICY INFORMATION

10. (a) I would like a(n) ______ Occurrence Policy ______ Claims-Made Policy

- A Claims-Made policy covers claims which arise and are made while the policy is in force.
- An Occurrence policy protects you against any claim arising during your policy period irrespective of when the claim is reported.

(b) If my application is approved, make coverage effective on __________________________, if possible, otherwise on any other date set by the Exchange. Month Day Year

11. (a) If prior professional liability insurance was on a claims-made basis, advise the retroactive date, or prior acts date. (Date you were first insured under a claims-made policy.) _________________________

(b) Do you know of any claims, collection problems, requests for patient records, infectious disease, or incidents that may give rise to potential claims, for dental services you provided that occurred during the period for which Prior Acts coverage is desired, that have not been reported to the previous carrier of record? ______ YES _____ NO

If YES, please explain

____

(c) Has there been any interruption in your professional liability coverage? _____ YES _____ NO *If YES, please explain in Remarks, (Question 38)*

12. **PLEASE CHECK THE APPROPRIATE LIMITS OF LIABILITY FOR WHICH YOU ARE APPLYING:**

_____ $ 500,000 Per Claim/$1,000,000 Annual Aggregate

_____ $1,000,000 Per Claim/$1,000,000 Annual Aggregate

_____ $1,000,000 Per Claim/$3,000,000 Annual Aggregate

_____ $1,300,000 Per Claim/$3,900,000 Annual Aggregate

13. Have you completed a formal RISK MANAGEMENT TRAINING PROGRAM in the last three years? If so, in what month and year _____________________ and what organization sponsored the program _________________________.

14. **CONSENT VS. NO CONSENT**

Physicians' Reciprocal Insurers has sought and obtained Insurance Department approval of a 5% premium reduction should you have a claim and authorize Physicians' Reciprocal Insurers to settle.

Those dentists who wish this option are asked to please check the first box below indicating the Insured's willingness to allow the Exchange to act on the Insured's behalf to settle any claim without obtaining written consent.

_____ **"NO CONSENT" OPTION**: I hereby authorize the Exchange to act on my behalf to settle any claim reported, or to appeal any judgement against me without first obtaining my written consent.

_____ **CONSENT OPTION**: I am not willing to forego my written consent prior to settling any claim on my behalf or appealing any judgement on my behalf.

15. What is your average weekly patient load? _______ Number of hours you are practicing per week? _______

If total hours is less than 16, explain why: ____

____

16. Outside practice (list names and addresses) for which you are not requesting coverage for from PRI:

____

____

____

17. I practice as a(n):

_______General Practitioner _________Periodontist __________Endodontist _______Oral Pathologist

______ Pedodontist _______Prosthodontist ______Orthodontist ________Oral Surgeon **(If so, PRI cannot cover you)**

What percentage of your practice is devoted to the following:

_____________Placing Implants
_____________Third Molar Extractions (please indicate type of extraction) ______________________________
_____________ Root Canals
_____________ Botox, Collagen or Restylane (If yes, please provide a certificate in training)

18. Do you treat patients who are rendered unconscious, by you or others, through the administering of Anesthesia or analgesia in a hospital? ________Yes _______No; in office _______Yes ________No

If "YES" to either, please explain: ____

____

19. (a) I practice as a sole practitioner and am _______incorporated as a P.C. ___________not incorporated

(b) I practice as an employee or member of a multi-dentist corporation ______Yes ______No

(c) I practice as an independent contractor _________ Yes ______No If yes, how many locations? ______

(d) I practice as a partner ______Yes ______No

If you would like to list your corporation as an Additional Insured on your policy, please indicate below:

____

____

____

20. If your practice is a partnership or corporation, do you desire a separate limit of liability (separate policy) for the entity, or a shared limit _____*SEPARATE _____SHARED

    * If you desire a separate limit and if the entity is a multi-shareholder corporation or partnership, you must complete a supplemental corporate/partnership application.

21. If you practice as a partner, or a member of a corporation with other dentists, list all partners or members' names and specialties:

    ____

    ____

    ____

22. Do you employ other dentists? _____ Yes ____ No If yes, how many? _____

23. If you, or your corporation, employ any dentists, list name(s), specialties and location(s):

    ____

    ____

    ____

24. Do you employ independent contractors? _____ Yes _____ No: If yes, how many? _____

25. If you, or your corporation, employ any independent contractors, list name(s), specialties and location(s):

    ____

    ____

    ____

26. Does every dentist with whom you practice in any capacity, in every location, have a dental malpractice insurance policy force? _____ YES _____ NO _____ DO NOT KNOW _____ NOT APPLICABLE

27. Is there anything special or unique about your practice? _____ Yes _____ No If yes, please explain:

    ____

    ____

28. Are you on staff or affiliated in any way with a hospital or clinic? ______ Yes _____ No If yes, please list names:

    ____

OTHER UNDERWRITING INFORMATION

29. Do you use a Collection Agency? _____ YES_____ NO

If "Yes", does this agency have authorization to file a collection suit on its own authority? _____ YES_____ NO

30. Have you ever been convicted of a felony? _____ YES_____ NO

31. Has any governmental agency ever investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice? _____ YES_____ NO
If "Yes", explain in Remarks, (Question 38)

32. Have you ever had professional liability insurance refused, declined, canceled or accepted on special terms? _____ YES_____ NO
If "Yes", explain in Remarks, (Question 38)

33. Have you ever had privileges at any hospital or other institution reduced, revoked, restricted or suspended? _____ YES_____ NO
If "Yes", explain in Remarks, (Question 38)

34. Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties? _____ YES_____ NO
If "Yes", explain in Remarks, (Question 38)

35. Have you ever been involved in a malpractice claim or suit, either directly or indirectly, or are you presently involved in malpractice litigation? _____ YES_____ NO
If "Yes", submit a separate claim activity form for each case in the last 10 years.

36. Are you presently in any litigation resulting from the dissolution of a dental partnership? _____ YES_____ NO
If "Yes", explain in Remarks, (Question 38)

37. List professional liability insurance carried for the past 10 years. If none, state none.

Insurance Company	Policy Number	Limits of Liability	Premium	Inception Month/Day/Year	Was This a Claims-Made Policy Form

38. **REMARKS** (PLEASE INDICATE QUESTION NUMBER(S) REFERRED TO):

____

____

____

39. List Professional Organizations or Associations of which you are a member:

____

40. List any Preferred Provider Organizations (PPO), Dental Maintenance Organizations, etc. in which you are a participating dentist:

____

The application duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the Exchange to issue coverage.

I understand that in order to underwrite professional liability insurance, the Exchange must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any dental society, dentist, hospital, insurance Exchange, underwriter, and insurance agent to furnish any information concerning me or my dental practice which the Exchange may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Exchange pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information.

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.

SIGNATURE ____ DATE____________________

CLAIM ACTIVITY
Be Sure to Answer All Questions Fully, Leave No Blanks

A. Name of Claimant or Plaintiff: ____
(Last) (First) (Middle Initial)

B. Date of Alleged Incident: ____

C. Name of Defense Counsel: ____

D. Name of Plaintiff's Counsel: ____

E. Location of Incident (County and State): ____

F. Issue or Type of Injury Claimed - What was the Objective Issue Contested in this Claim?

Injury: _____ Emotional Only _____ Cosmetic _____ Temporary Disability _____ Permanent Disability

_____ Death _____ Injury with Economic Impact

Treatment Involved: ____

Please state allegations filed against you by patient: ____

____

At what point in the treatment provided could this incident have been avoided either by a different action on your part or help from another treating dentist? Please be candid.

____

____

G. Were other dentists or hospitals involved as co-defendants? ________ YES ________ NO
Please list their names:

____

____

H. If you were one of many defendants in this legal action and your treatment was criticized by any of the dentists involved, what were the allegations against you?

____

____

I. Name of the insurance company defending you: ____

J. Was claim or suit actually brought against you, merely threatened, or limited to claimant's attorney contact? ______________________
____

K. If suit was filed, include the court docket number, if known: ____

L. Disposition: What happened to the claim?

_____ Abandoned (no activity over 3 years) _____ Won by defense _____ Judgement or verdict vs. co-defendant(s) only

_____ Settled or _____ Won by claimant If so, how much was paid on your behalf?________________When?____________________

What was the reason for payment on your behalf?____

_____ Open (state current status)____

How much has the insurance company set aside in reserve for this claim? (If known) ____