PHYSICIANS' RECIPROCAL INSURERS
1800 Northern Boulevard
P.O. Box 9007
Roslyn, NY 11576
(516) 365-2855
Toll Free: (888) 526-4006

APPLICATION

FOR DDS/DMD CORPORATE/PARTNERSHIP PROFESSIONAL LIABILITY COVERAGE

IMPORTANT INSTRUCTIONS

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY

Please note: this application cannot be submitted electronically; once completed, it will need to be printed, signed and then forwarded to PRI via mail(516-869-6421) , fax or email (pridental@medmal.com).

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.

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CORPORATE/PARTNERSHIP APPLICATION
(Do not complete for sole shareholder corporation)

Please type or print.

A. Professional corporation/partnership name:

_____

_____

1. _____
Office Address

_____
City State Zip County

2. _____
Office Phone Number

3. _____
President/Partner

4. _____
Business Manager/Administrator

5. The legal entity above is: ☐ Professional Corporation ☐ Partnership ☐ Other

(If other Please Describe) _____

_____

B. Professional Liability Coverage

1. Coverage can be written on a shared limit of liability basis with all others insureds or on a separate policy.

2. Limits of liability*_____ each claim $_____ annual aggregate $_____

*Note: If a separate policy is desired, the limit of liability will be equal to the highest limits provided by us to the individual dentists.

3. Desired "Initial Coverage" date _____

Below, please list the names and dental specialties of all individual dentists who are stockholders, partners or employees. If any individual dentist is not insured by PRI, indicate current insurance carrier and current limits of liability.

Dentist, Stockholder / Partner's Name	Specialty	Applying to PRI?	Answer if not Insured by Physicians' Reciprocal Insurers	
			Carrier	Limits of Liability
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

4. How many of the following personnel are employed by the entity?

_____Dental Hygienist _____Dental Assistants/Technicians

5. Does the entity employ nurse anesthetists? ☐ No ☐ Yes

6. Has any insurer canceled or declined coverage or refused renewal for any insurance? (If yes, please explain on a separate piece of paper.) ☐ No ☐ Yes

7. Has any claim or suit for alleged malpractice ever been brought against your professional corporation or partnership, or are you aware of any circumstances that might reasonably lead to such a claim or suit? (Give full details on claim supplement form.) ☐ No ☐ Yes

I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not withheld any information which is calculated to influence the judgement of the Exchange in considering this application for professional liability insurance.

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.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES 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.

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 company, 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 organization will not be liable to me in any way for furnishing such information.

_____ _____

Signature of President/Partner Date

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