Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
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ALLIED MEDICAL DENTAL PROFESSIONAL SUPPLEMENTAL APPLICATION

Submit with Allied Medical General Application

Every statement MUST be completed. Write "NONE" if that applies. PLEASE TYPE OR PRINT.

SECTION I: GENERAL INFORMATION (To be completed by all applicants) Agent_____

1. Full Name _____ ☐ Male ☐ Female ☐ Date of Birth
Last First M.I.

2. Home Address _____ City_____ State _____ Zip_____

3. Mailing Address _____ City_____ State _____ Zip_____
(If different from home address)

4. Home Telephone (____) _____ Professional Degree_____ Lic# _____ State_____

5. I practice as:

☐ Solo Practitioner - UNINCORPORATED Revenue $ _____

☐ EMPLOYEE or INDEPENDENT CONTRACTOR (List name of each employer)_____

☐ PARTNERSHIP (List name of partners) *_____

☐ PROF. CORP. or PROF. ASSN. (List name of corp. & principals) * _____
_____

*** All members of a partnership as well as all shareholders of a professional corporation who practice dentistry must be covered under**

6. Character of Practice: ☐ General ☐ Endodontics ☐ Oral & Maxillofacial Surgery ☐ Oral Pathology ☐ Orthodontics

☐ Pedodontics ☐ Periodontics ☐ Prosthodontics ☐ Other _____

SECTION II: COVERAGE REQUEST

1. Plan of Insurance Desired:

☐ Occurrence ☐ Claims Made ☐ Bridge

2. Requested Limits of Liability:

☐ $100,000/$300,000 ☐ $200,000/$600,000
☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

3. Requested Effective Date: ____/____/____

4.*Requested Retroactive Date: ____/____/____
*To be completed by all applicants who are leaving an existing claims made program. Refer to the declarations page of your policy to determine the retroactive date.
Attach a copy of the current declarations page showing the retroactive date.

5. List Your Professional Liability Insurance carrier for each of the **last five (5) years.** If none, state NONE.

Inception Date	Expiration Date	Name of Insurance Company	Policy Number	Premium	Limits of Liability

SECTION III: PRIOR EXPERIENCE

☐ **Yes** ☐ No 1. Has there ever been a claim or suit, settled or pending, made against you for malpractice and/or peer review?
If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.

☐ **Yes** ☐ No 2. Do you have reason to believe that your past treatment of, or failure to treat a patient may result in a claim or suit against you or any dentist associated in practice with you?
If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.

☐ **Yes** ☐ No 3. Has any claim or suit ever been brought against any dentist associated in practice with you as a result of alleged malpractice, error or mistake?
If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.

☐ **Yes** ☐ No 4. Have you ever appeared before the state licensing agency for professional misconduct?
If "Yes," please provide a copy of the board's findings.

☐ **Yes** ☐ No 5. Has any disciplinary action been taken by **or** a complaint lodged with, a government agency, hospital, or professional association against you or any of the past or present principals, partners or officers, or any dentist associated with you ?
If "Yes," please provide a copy of the complaint and the final order and/or stipulation:

☐ **Yes** ☐ No 6. Have you ever been refused board certification?
If "Yes," please give details:_____
_____

☐ **Yes** ☐ No 7. Has any insurance company ever declined, failed to renew, or cancelled a Professional Liability Policy for you?
If "Yes," please list company, date, and reason:_____
_____

8. How many suits for collection of fees have been filed by you during the past two years?_____

SECTION IV: PROFILE OF PRACTICE

1. How many locations do you practice at?_____ Complete the following for each location. **(Space is provided for two (2) locations. If you are involved in more than two (2) locations, please copy as needed.)**

a. Name of Facility _____

b. Street Address_____City_____State_____Zip_____

c. County_____Phone (_____)_____Fax (___)_____

d. What is your professional relationship with this facility? **(Check all that apply)**
☐ Owner ☐ Employee ☐ Independent Contractor ☐ Manager ☐ Supervisor ☐ Director
☐ Other (please explain) _____

e. Time spent at this location: Days per week_____Hours per week_____

f. How many dentists, **(excluding yourself)**, are engaged in practice at this location? _____

g. For each of these dentists provide their specialty and hours per week spent practicing at this location:

Specialty	Hours per week	Specialty	Hours per week

h. Except as to referrals to specialists, are you solely responsible for the treatment and follow-up care for your patients?
☐ Yes ☐ **No. If "No," please explain:** _____
_____

a. Name of Facility _____

b. Street Address_____City_____State_____Zip _____

c. County_____Phone (____)_____Fax (____)_____

d. What is your professional relationship with this facility? **(Check all that apply)**

□ Owner □ Employee □ Independent Contractor □ Manager □ Supervisor □ Director

□ Other (please explain) _____

e. Time spent at this location: Days per week_____Hours per week_____

f. How many dentists, **(excluding yourself)**, are engaged in practice at this location? _____

g. For each of these dentists provide their specialty and hours per week spent practicing at this location:

Specialty	Hours per week	Specialty	Hours per week

h. Except as to referrals to specialists, are you solely responsible for the treatment and follow-up care for your patients?
□ Yes □ **No. If "No," please explain:** _____

2. Dental School Attended_____ Year Graduated_____ Year Licensed_____

□ **Yes** □ No 3. Do you employ any dentists as employees or independent contractors?
If "Yes," how many? _____

□ Yes □ No a. Are any of these employees or independent contractors oral and maxillofacial surgeons?

□ Yes □ No b. Do any of these employees or independent contractors treat patients with general anesthetics, intravenous or intramuscular sedatives?

□ **Yes** □ No 4. Do you rent space to, or otherwise share office space with any dentists who are oral and maxillofacial surgeons, or treatpatients with general anesthetics, intravenous or intramuscular sedatives?
If "Yes," please explain: _____

□ Yes □ **No** 5. Do you take a written health history on every patient in your practice? **ATTACH A COPY OF THE HEALTH HISTORY FORM USED IN YOUR PRACTICE.**
If "No," please explain:_____

□ **Yes** □ No 6. Do you surgically insert fixtures or other types of implants?
If "Yes," please complete items a-c below:

a. How many cases per year?_____

□ **Yes** □ No b. Have you completed a post-doctoral residency program in a hospital or dental school?
If "Yes," indicate:

Type_____ Duration _____

Year Completed _____Hospital or Dental School_____

□ **Yes** □ No c. Have you completed any surgical training program in the use of implants and fixtures?
If "Yes," indicate:

Year Completed_____ Sponsoring Agency _____

Duration of Training _____

□ **Yes** □ No 7. Do you accept **REFERRALS FROM OTHER DENTISTS** for the treatment of patients exhibiting Temporomandibular Joint Dysfunction (TMD)?
If "Yes," please explain: _____

□ **Yes** □ No 8. Are you licensed or operating as a professional other than a dentist?
If "Yes," please describe:_____
_____

☐ **Yes** ☐ No 9. Are you on staff, or affiliated in any way with a hospital or clinic?
If "Yes," complete the following:

Institution _____

Days per Week ____

Address _____ City _____State _____ Zip _____

Nature of Duties _____

☐ **Yes** ☐ No 10. Have you ever experienced, or are you currently experiencing alcoholism, narcotic addiction, or mental illness?
If "Yes," please give details: _____

☐ **Yes** ☐ No 11. During the past 5 years have you been under the care of a physician?
If "Yes," describe why treatment was sought, current status and date of last visit: _____
_____

☐ **Yes** ☐ 12. Have you ever practiced in any state(s) other than listed in Section I, No. 4?
If "Yes," list states: _____

☐ Yes ☐ No 13. Are you an Oral and Maxillofacial Surgeon?

☐ Yes ☐ No 14. Do you treat patients who are rendered unconscious **BY YOU OR OTHERS**, through the administering of anesthetics or analgesics **IN A HOSPITAL OR OFFICE**?

☐ Yes ☐ No 15. Do you provide treatment to any patient who has been sedated with the use of any I.V. or I.M. sedatives?

☐ Yes ☐ No 16. Do you provide treatment to any patient who has been sedated with the use of general anesthetics?

☐ **Yes** ☐ No 17. Do you provide treatment to any patient who has been sedated with nitrous oxide and oxygen? ☐
☐ **Yes** ☐ No **If "Yes," does your equipment have FAIL-SAFE DEVICES?**

☐ **Yes** ☐ No 18. Do you use any pre-treatment medication (other than local anesthetics)?
If "Yes," describe and indicate drugs used and method of administering:
_____

☐ **Yes** ☐ No 19. Do you use Sargenti Paste in performing endodontic procedures?
If "Yes," indicate the number of cases per year: _____

SECTION V: 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

Hours per Day: _____ _____ _____ _____ _____ _____

SECTION VI: REPRESENTATION AND ACKNOWLEDGEMENT (To be completed by all 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

Representation: I represent that the information contained herein is true and that it shall be the basis of the policy of Insurance and deemed incorporated therein, should the company/underwriter evidence its acceptance of this application by issuance of a policy. I further represent that I have not withheld any information which is reasonably likely to influence the judgement of the company/underwriter considering this application (i.e. prior claims, prior difficulties with authorities, prior cancellations or refusals to renew by insurance companies, prior lapses of coverage, etc.). If I have withheld any such information, I understand that my coverage may be voided. I further understand that my failure to disclose any information in my possession regarding possible incidents which may lead to claims will relieve the insurance company of any obligation under Prior Acts coverage.

I hereby authorize the insurance company, its agents and representatives to secure claims information from my current and previous insurance carriers.

CLAIMS-MADE APPLICANTS ONLY: I have requested my policy be written on a "Claims-Made" form and acknowledge that this policy will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" policy will not provide insurance coverage for claims which occurred prior to the Prior Acts date of my policy.

I understand that should my "Claims-Made" policy with this insurance carrier ever be cancelled or non renewed, or I decide to terminate it for any other reason, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy but were not reported to the insurance company before the date of the policy termination, I will be required to purchase additional insurance coverage.

SIGNING THIS FORM DOES NOT BIND THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. NO INSURANCE SHALL BE GRANTED UNLESS ALL QUESTIONS ARE ANSWERED AND THE APPLICATION IS SIGNED AND DATED.

Signature_____Date Signed_____

Agent Signature _____ Date Signed_____

Agent's License #_____