DENTAL PROFESSIONAL LIABILITY APPLICATION

FORTRESS INSURANCE COMPANY
dds4dds.com
(800)522-6675

GENERAL INFORMATION

NAME _____ SUFFIX: ☐ DDS ☐ DMD OTHER _____
FIRST MIDDLE LAST

DATE OF BIRTH _____ OFFICE PHONE _____
AREA CODE

GENDER ☐ Male ☐ Female HOME PHONE _____
AREA CODE

EMAIL _____ CELL PHONE * _____
AREA CODE

COVERAGE INFORMATION

REQUESTED EFFECTIVE DATE _____ **COVERAGE TYPE** **Claims Made** - Retroactive Date _____

LIMITS OF LIABILITY REQUESTED (each person / aggregate limit)

☐ $250,000 / $750,000 ☐ $500,000 / $1,000,000 ☐ $1,000,000 / $3,000,000 ☐ $1,300,000 / $3,900,000 ☐ $2,000,000 / $6,000,000

1. LIST ALL PREVIOUS PROFESSIONAL LIABILITY CARRIERS IN THE LAST TEN YEARS

	Insurance Company	From (MM/YYYY)	To (MM/YYYY)	Coverage Type
Current:				☐ Claims Made ☐ Occurence
Previous:				☐ Claims Made ☐ Occurence

Please explain any gaps in coverage within the past ten years: _____

Has your professional liability insurance ever been cancelled or non-renewed? ☐ **Yes** ☐ **No**

2. **DO YOU HAVE A PRACTICE LOCATION THAT IS COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY**? ☐ **Yes** ☐ **No**

PRACTICE NAME _____ NAME OF INSURER _____

PRACTICE ADDRESS _____
STREET CITY STATE ZIP

PRACTICE INFORMATION

If you practice at more than one location, please list additional locations.

PRACTICE NAME _____

PRACTICE ADDRESS _____
STREET CITY STATE ZIP

MAILING ADDRESS _____ ☐ Same as practice.
STREET CITY STATE ZIP

BILLING ADDRESS _____ ☐ Same as practice.
STREET CITY STATE ZIP

1. TYPE OF LOCATION
   - ☐ Dental Office
   - ☐ Dental Service Organization/Management Organization
   - ☐ Governmental Office
   - ☐ Mobile Dental Unit
   - ☐ Nursing Home
   - ☐ Correctional Facility

2. YOUR ROLE AT THIS LOCATION
   - ☐ Sole Owner
   - ☐ Partner/Member/Shareholder
   - ☐ Employee
   - ☐ Independent Contractor

3. Is this practice currently insured with Fortress? ☐ **Yes** ☐ **No** ☐ **Unknown**

4. **ENTITY COVERAGE:** If you are a **sole-owner** or a **partner/shareholder**, please select entity coverage if desired:

☐ **Shared Limit** - Your individual policy limits will be shared with your **Solo Corporation**. This option is only available if you are solo incorporated. No additional premium required.

☐ **Separate Limit** - Available for all Entity/Organization Types. A separate entity application is required. Please contact your Fortress agent for pricing and application information.

EDUCATION & LICENSURE

DENTAL SCHOOL _____ DEGREE _____ GRADUATION (MM/YYYY) _____

POST-GRADUATE TRAINING _____ DEGREE _____ GRADUATION (MM/YYYY) _____

Specialty - please check all that apply:

☐ General Dentistry ☐ Endodontics ☐ Pediatric Dentistry ☐ Oral & Maxillofacial Pathology
☐ Dental Anesthesiology ☐ Orthodontics ☐ Prosthodontics ☐ Oral & Maxillofacial Radiology
☐ Dental Public Health ☐ Periodontics ☐ Oral & Maxillofacial Surgery

Professional Organization Memberships: ☐ ADA ☐ AGD ☐ State Assn of _____ ☐ Other: _____

License Type(s)	State(s)	License Number(s)

Have any professional licenses been investigated, disciplined, revoked, suspended or placed on probation? ☐ **Yes** ☐ **No**
Please provide a copy of the documentation received as well as a narrative of the events that led up to the above.

Have you taken a risk management course given by an ADA CERP or PACE Provider within the past 3 years? ☐ **Yes** ☐ **No**

PRACTICE DETAILS

Please list all previous practice locations in the past ten years:

Name of Practice	Street Address	City, State	Dates Worked (MM/YY to MM/YY)

1. Select any market segment that represents more than 50% of your annual revenues:
   ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other _____
2. Are you requesting part-time coverage? If yes, reason for practicing part-time: _____ ☐ **Yes** ☐ **No**

Average number of:

1. Hours you practice per week: _____
2. Patients you treat per week: _____
3. Surgical placement of implants performed or plan to perform on an annual basis: _____
4. Extractions of impacted teeth performed or plan to perform on an annual basis: _____

Do you:

1. Administer sedation/anesthesia in your practice? ..... ☐ **Yes** ☐ **No**
   Check all that apply: ☐ Local anesthesia ☐ Multi-dose oral sedation ☐ Nitrous oxide ☐ IV/IM - moderate sedation ☐ General anesthesia/deep sedation
2. Provide anesthesia to patients other than your own? ..... ☐ **Yes** ☐ **No**
3. Allow another professional to administer sedation to your patients? ..... ☐ **Yes** ☐ **No**
4. Teach or train dental students or dental professionals? ..... ☐ **Yes** ☐ **No**
   If yes, what is the name of the institution? _____
5. Provide treatment for Obstructive Sleep Apnea (OSA)?..... ☐ **Yes** ☐ **No**
   If yes, do you obtain a referral from the patient's physician before treatment? ☐ **Yes** ☐ **No**
6. Provide same-day dentures in your practice? ..... ☐ **Yes** ☐ **No**
7. Provide alternative or holistic treatment modalities in your practice? ..... ☐ **Yes** ☐ **No**
8. Provide teledentistry services in your practice?..... ☐ **Yes** ☐ **No**
9. Perform cavitation surgery in your practice? ..... ☐ **Yes** ☐ **No**
10. Contract with or work for a staffing agency or locum tenens agency? ..... ☐ **Yes** ☐ **No**

CLAIMS & EXPERIENCE

If you answer yes to any of the following questions, please provide an explanation.

Have you:

1. Ever been charged or convicted of a criminal offense? ☐ **Yes** ☐ **No**
2. Ever been a participant in a drug or alcohol dependency program? ☐ **Yes** ☐ **No**
3. Become aware of any illness or physical disability that could impair your ability to practice? ☐ **Yes** ☐ **No**
4. Ever been investigated for/or charged with fraud, including Medicare/Medicaid fraud? ☐ **Yes** ☐ **No**
5. Ever been subject to a malpractice claim? ☐ **Yes** ☐ **No**

   If yes, please complete a Claim Supplement form for each claim and submit a loss run from all carriers that provided coverage during the past ten years.
6. Become aware of any incidents that might give rise to a malpractice claim? ☐ **Yes** ☐ **No**

Please use this section to provide any additional information requested above in the application. Please reference the question for which you are providing additional information. If additional space is needed, please attach a separate page.

Question	Additional Information

*Telephone Consumer Protection Act Consent

By providing a Cell Phone number, I agree to receive calls and/or texts to that number from the Company or its authorized representative, regarding my application for coverage or service regarding my coverage. I understand these calls may be generated using an automated technology. I understand my consent is not a condition of purchase.

Privacy Notice

Fortress Insurance Company considers all transactions with us private and confidential. The United States Department of Health and Human Services has issued an opinion letter indicating that the obtaining and maintaining of professional liability insurance is a part of health care operations and therefore would not require a business associate agreement nor any releases for disclosure of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).

We may use and disclose Protected Health Information in our possession for proper management, administration and/or to fulfill any present or future legal responsibilities provided that the disclosures are required by law; or that such uses are permitted under state and federal confidentiality laws; or that we have received assurances of the confidential handling of such Protected Health Information.

We require all subcontractors and agents that perform the services we are obligated to perform under this application to adhere to the same restrictions and conditions on the use and disclosure of Protected Health Information that apply to you and to us for any Protected Health Information that they receive, use or have access to.

Should this application be declined or withdrawn, the protections of this statement will remain in force, and we shall make no further uses and disclosures of your Protected Health Information, except for the proper management and administration of our business or as required by law.

Prior Acts Certification

If you ask us to provide coverage for "Prior Acts" ("Nose Coverage") for your professional liability exposure, you must inform all prior carriers of any claims, incidents or circumstances that might lead to a claim being made against you. Please provide written documentation that verifies you have informed all prior carriers of such incidents, etc. It is not the intent of the Fortress Policy to cover such known patient injuries. Your prior carriers should cover incidents/claims arising out of these injuries. Please read and sign the following statement:

I certify that I am not aware of any incidents or circumstances, which I might expect to result in a claim, except those listed in this application for insurance. I understand that my Fortress Policy will not provide coverage for such incidents of which I am aware regardless of whether I have reported them to my prior insurance carriers.

Acknowledgement

I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and I have not omitted or withheld any fact or circumstance, which would be relied upon in the determination by Fortress Insurance Company ("Company") in granting liability insurance. I understand that this application, and any documents provided are made a part of the policy that is issued. Further, I agree to abide by any recommendations of the Company with regard to loss prevention issues.

I authorize any state board of examiners or licensers, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to the Company or its assigns. I authorize the use of a copy of this Acknowledgement in lieu of its original.

I understand the execution of this application is not a guarantee of coverage and that the Company may, in its sole and absolute discretion, accept or reject this application for professional liability insurance coverage. This acknowledgement shall be governed and interpreted in accordance with the laws of the state in which this policy is issued.

Warning

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 _____