Fortress Insurance Company Dental Professional Liability Application For New To Practice Dentists

PLEASE COMPLETE THIS APPLICATION IF YOU ARE A RECENT DENTAL SCHOOL GRADUATE AND THIS IS YOUR FIRST TIME ENTERING THE PRACTICE OF DENTISTRY.

PLEASE INDICATE THE TYPE OF COVERAGE REQUESTED: ☐ INDIVIDUAL COVERAGE ☐ ENTITY COVERAGE ☐ BOTH

I. General Information

1. Name: _____ Suffix: ☐ DDS ☐ DMD ☐ Other _____
2. Date of Birth: _____ Social Security #: _____
3. Practice Address: _____
   City: _____ County: _____ State: _____ Zip: _____
   % of time spent at location: _____%
   Please provide all additional locations requiring Fortress coverage on a separate sheet of paper
4. Mailing Address (If different than practice address): _____
   City: _____ County: _____ State: _____ Zip: _____
5. Billing Address (If different than practice address): _____
   City: _____ County: _____ State: _____ Zip: _____
6. Office Phone: _____ Office Fax: _____ Home Phone: _____
   Email Address: _____ Website Address: _____

II. Coverage Information

1. Requested Effective Date: _____
2. Coverage Type: ☐ Claims-Made ☐ Occurrence
3. Limits Requested (each person/aggregate limit): ☐ VA Cap Limits
   ☐ $250,000/$750,000 ☐ $500,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$6,000,000

III. Education & Licensure

1. Dental School: _____ Degree: _____ Year Graduated: _____
   Post-Graduate Training: _____ Degree: _____ Year Graduated: _____
   Please do not abbreviate the institution's name
2. Please indicate the professional organizations of which you are a member:
   ☐ ADA ☐ AGD ☐ _____ State Association ☐ Other _____
3. Please indicate your Specialty:
   ☐ General Dentistry ☐ Dental Anesthesiology ☐ Oral & Maxillofacial Surgery
   ☐ Endodontics ☐ Orthodontics ☐ Oral & Maxillofacial Radiology
   ☐ Pediatric Dentistry ☐ Periodontics ☐ Oral & Maxillofacial Pathology
   ☐ Prosthodontics ☐ Dental Public Health
4. Please provide the following information for all active and inactive professional licenses you possess:

Type (Dental, DEA etc)	State	License #

5. Have you ever been denied the right to take a dental licensure examination by any state, territory, or district? **If yes, please provide explanation on a separate sheet of paper** ☐ Yes ☐ No

IV. Practice Information

1. Please indicate all location types for which you are requesting coverage:

   ☐ Dental Office ☐ Nursing Home ☐ Mobile Dental Unit
   ☐ Government Office ☐ Hospital ☐ Imaging Facility
   ☐ Surgi-Center ☐ Dental Laboratory ☐ Other _____

2. Please indicate the average number of hours you practice per week for which you require Fortress coverage: _____
3. If you practice on average less than 20 hours per week/1,000 hours per year as stated in question #4 above, are you requesting part time coverage? **If yes, please provide explanation on a separate sheet of paper** ☐ Yes ☐ No
4. Do you obtain a dental/medical history for all patients? **If yes, attach a sample of each form** ☐ Yes ☐ No
5. Do you obtain written informed consent for all patients? **If yes, attach a sample of each form** ☐ Yes ☐ No
6. Do you have privileges at any hospital? **If yes, please submit a delineation of privileges** ☐ Yes ☐ No
7. Do you administer any sedation/anesthesia in your practice? ☐ Yes ☐ No
   If yes, please mark all that apply to your practice:

   ☐ Local Anesthesia ☐ Nitrous Oxide ☐ Multi-Dose Oral Sedation
   ☐ PO/Enteral — Minimal Sedation ☐ IV/IM — Moderate Sedation ☐ General Anesthesia – Deep Sedation
   ☐ Sedation/anesthesia to patients other than your own
   ☐ Sedation/anesthesia to special needs patients

8. How many of the following procedures do you intend to provide on an annual basis:
   Surgical Placement of Implants _____ Extractions of Impacted Teeth _____
9. Do you perform any procedures unrelated to the diagnosis and treatment of teeth and the oral cavity? **If yes, please submit a detailed explanation of the procedure, the quantity performed and the purpose of the procedure on a separate sheet of paper** ☐ Yes ☐ No
10. Do you utilize injectable neurotoxins (i.e. Botox) and/or Dermal Fillers (i.e. Artefill, Collagen, Hylaform, Restalyne) in your practice? **If yes, please complete the Facial Cosmetic Procedure Supplement to apply for coverage. Please note coverage may not be available in all states.** ☐ Yes ☐ No

V. Claims & Experience Information

Please explain all yes answers to Questions 1-3 on a separate sheet of paper

1. Have you ever been charged or convicted of a criminal offense? ☐ Yes ☐ No
2. Have you ever been a participant in a drug or alcohol dependency program? ☐ Yes ☐ No
3. Have you experienced or become aware of any illness or physical disability that impairs or could impair your ability to practice dentistry? ☐ Yes ☐ No

VI. Entity Affiliations (Entity Includes Any Dental Corporation, Partnership, Group Or Other Legal Entity)

1. Practice Affiliation: ☐ Owner ☐ Employee ☐ Independent Contractor
2. Do you practice on behalf of a dental corporation, partnership, group or entity? ☐ Yes ☐ No
   If yes, please complete the following:
   a. What is the legal name of the entity? _____
   b. List any Doing Business As names (DBA's): _____

   If ownership interest exists in the entity(s) named above, please complete question #3

3. Please indicate which coverage is desired for your entity by initialing your selection:

   _____ Initial Here — Add my sole shareholder entity as an Additional Insured on my individual policy to share in my limits of liability with no additional premium charge.

   _____ Initial Here — Issue a separate entity policy with a separate set of limits of liability for an additional premium charge. I have completed the Entity Supplement and have attached it to this application.

   _____ Initial Here — I do not wish to obtain coverage for my entity at this time.

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.

Warning

Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud. Such person may be subject to denial of insurance benefits, civil penalties and/or criminal penalties.

In CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In KY: Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In PA: 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 subjects a person to criminal and civil penalties.

In VA & ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

In FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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.

Signature _____ Date _____

Virginia Cap Limit

I understand that if I elect to participate in the Virginia Cap, my liability limits will increase annually as the recoverable amount increases.

Signature _____ Date _____

Agent Signature: _____