Application for Professional Liability Coverage

Berkley Risk Service of Colorado
Administrators

IMPORTANT

Information you need to know before completing the application.

1. To apply for professional liability coverage through the Dentists Professional Liability Trust of Colorado, you must be a member of the Colorado Dental Association or have an application for membership pending.

2. To maintain your coverage you must remain a member of the Colorado Dental Association.

3. We appreciate your efforts in accurately completing the application. Despite the length and scope, it is essential that we obtain adequate information so that underwriting can be completed.

4. **It is essential that all statements be completed and questions answered**. Failure to complete appropriately may delay or prevent the underwriting of your application. Your signature is also required. If additional space is needed, use the appropriate section where applicable. One or more Supplemental Application Forms must be completed and signed to report any Peer Review, State Board or malpractice claims. For those participants that are renewing with the Trust, only documenting any incidents/claim or suit since your last renewal is required. Print and sign the completed application.

5. We urge you to complete your application **immediately**.

6. A copy of your stationery, business card, yellow page listing or business advertisement and any other promotional material must be submitted along with the application.

7. When the application is completed and all documents gathered, please return in the enclosed reply envelope: This packet contains the following documents

a	Application for Professional Liability Coverage	Pages 1-6
b.	Agreement to maintain CDA membership	Page 7
c.	Supplemental Application	Page 8
d.	Application for Retroactive Coverage	Pages 9 -10
e.	Alternative location schedule	Page 11
f.	HIPAA Business Associate Contract	Pages 12 - 16
g.	Participation Agreement	Pages 17 - 18

Mail to: DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO
c/o Berkley Risk Services of Colorado
2000 S. Colorado Blvd.
Annex Building, Suite 410
Denver, CO 80222

9. Please retain the **AMENDED TRUST AGREEMENT**, which is included with this application, for your records.

Our underwriting process involves a thorough evaluation of your application and requires a few days to a few weeks depending on the application to complete underwriting process. Please consider this time frame when submitting your application. Until you are approved, you **DO NOT** have coverage.

You should not see patients **UNLESS** you have current coverage.

If you have questions concerning the completion of this application or questions about the Trust, please call 303-357-2613 or toll free 877-502-0113.

APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE

To be eligible you must be a member of the CDA or have application pending.

If a policy is issued, it will be on a claims-made basis.

PROFESSIONAL LIABILITY APPLICATION

1. Name of Applicant ______________________________

   Mailing Address
   ____
   ____
   ____

   Location of Practice
   ____
   ____
   ____

Tax I.D. # ______________________
Date of Birth ______________________

Social Security Number ______________________

Telephone Numbers
Office ______________________
Home ______________________
Cell ______________________
Web page ______________________
Email ______________________

Date Coverage is to be effective ______________

2. The coverage is:

   Professional Liability $2,000,000 Each Claim $6,000,000 Aggregate

List past Professional Liability Carriers

Name of Carrier	Limits of Liability	Period of Coverage	Occurrence Policy	Claims Made Policy
			☐	☐
			☐	☐
			☐	☐

IF ADDITIONAL SPACE IS NEEDED TO ANSWER QUESTIONS #4 THROUGH #18, PLEASE USE PAGE 5 OR LETTERHEAD

Colorado Dental License #__________ DEA# ______________ Expiration Date __________________

Licenses current and in force? ☐ Yes ☐ No

List all other states in which you are presently, or have previously been, licensed:

State	License Number	Current?

List all addresses and locations where you have practiced if other than above.
____
____
____

Rev 05/10

Administered by:
Berkley Risk Services of Colorado
2000 S. Colorado Blvd. • Annex Building, Suite 410 • Denver, CO 80222
Phone: (303) 357-2600 • (877) 502-0100 • Fax: (866) 699-1559

Have any of your licenses ever been suspended, revoked or put on probation by any regulatory board or agency?
If yes, explain in detail on page 5 or on letterhead. ☐ Yes ☐ No

3. School of graduation ______________________ __________ Degree __________ Year
If foreign dental school graduate, are you certified by the Educational Council for Dental School graduates?
If Yes, year of certification ____________ ☐ Yes ☐ No

Are you certified by an approved specialty board? .... ☐ Yes ☐ No
If yes, indicate "Board Certified," "Board Eligible," or Practice limited to ______________________

Area of practice:

- ☐ General Practitioner
- ☐ Oral Surgeon
- ☐ Periodontist
- ☐ Prosthodontist
- ☐ Endodontist
- ☐ Pediatric Dentist
- ☐ Orthodontist
- ☐ Other ______________________

If you are a general dentist, do you "limit your practice" to any area of dentistry?....................................... ☐ Yes ☐ No
Area ______________________

Do you advertise any specialty other than those recognized by the ADA?.. ☐ Yes ☐ No

Dental Public Health
Oral and Maxillofacial Pathology
Oral and Maxillofacial Radiology
Oral and Maxillofacial Surgery
Orthodontics and Dentofacial Orthopedics
Endodontics
Prosthodontics
Pediatric Dentistry
Periodontics
Other ______________________

Served internship or residency at ______________________ Year__________

Are you in compliance with the CDA continuing dental education requirements the last 3 years?.............. ☐ Yes ☐ No
Have your continuing education hours been reported? .... ☐ Yes ☐ No

Specify name and location of hospitals of which you hold staff or courtesy privileges: JCAH APPROVED
☐ Yes ☐ No
☐ Yes ☐ No

What professional organization are you a member of? ☐ ADA ☐ CDA ☐ Other
If "other", please indicate full name ______________________

4. Do you practice as:
☐ Individual ☐ Partnership ☐ Professional Corporation ☐ Professional Association
☐ Contract dentist ☐ Other ______________________
Name of partners or members of corporation, professional association or your employer.
____
____

Are other dentists employed or contract providers employed by you? ☐ Yes ☐ No Number employed __________
Are they Trust dentists? .... ☐ Yes ☐ No

YOUR PROFESSIONAL CORPORATION CAN ONLY BE COVERED, BASED ON THE POLICY PROVISIONS, IF ALL DENTISTS ARE COVERED BY THE DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO.

YOU MUST PROVIDE ALL STATIONERY, BUSINESS CARDS, YELLOW PAGE LISTINGS, PROMOTIONAL MATERIAL AND ADS USED BY YOUR OFFICE.

5.a. Are you employed full time by the Federal Government or are you in the military service? ☐ Yes ☐ No

b. Do you own or operate a hospital, sanitarium, or clinic with regular bed or board facilities? ☐ Yes ☐ No

c. Do you own, operate, or use free standing surgicenter facilities? ☐ Yes ☐ No

d. Has any hospital ever restricted or revoked your privileges, or has probation been invoked? ☐ Yes ☐ No

e. Has your dental or narcotics license ever been suspended, revoked, or voluntarily surrendered, or has probation been invoked? ☐ Yes ☐ No

f. Have you ever been denied a dental license or been denied certification by a specialty board? ☐ Yes ☐ No

g. Has any similar insurance for you, your present partner, employer, owner, employees, associates or predecessor ever been declined, cancelled or non-renewed? ☐ Yes ☐ No
explain: ______________________________

h. Have any professional liability (malpractice), Peer Review or State Board claims **EVER** been made against you? ☐ Yes ☐ No

YOU MUST COMPLETE THE ENCLOSED SUPPLEMENTAL REPORT FORM REGARDLESS OF YOUR ANSWER TO THE ABOVE QUESTION.

i. Have you ever had a problem with or difficulty with controlling the use of drugs or alcohol? ☐ Yes ☐ No

j. Within the last two years, have you used prescribed or nonprescribed psychoactive drugs? ☐ Yes ☐ No

k. Have you been treated within the last five years for a drug or alcohol related problem? ☐ Yes ☐ No

l. Have or are you now restricted in your practice by any mental or physical disablement or handicap? ☐ Yes ☐ No
Describe: ______________________________

m. Have you ever practiced without liability coverage? ☐ Yes ☐ No
explain: ______________________________

DESCRIBE ALL "YES" ANSWERS FULLY ON PAGE 5 OR ON LETTERHEAD

6. Provide the names, addresses, telephone numbers, and if possible, E-mail address and fax number of two dentists whom we may contact regarding your practice style, quality and manner in which you practice.

____
____
____
____
____
____

7. Indicate the approximate percentage of your time spent in each of the following applicable areas:

- ____ % Examination , diagnosis, and treatment planning
- ____ % Implantology ☐ Surgical ☐ Restorative/Reconstruction
- ____ % Pediatric Dentistry
- ____ % Operative Dentistry
- ____ % Orthodontics
- ____ % Endodontics
- ____ % Periodontics
- ____ % Preventive Dentistry
- ____ % Prosthodontics, Fixed
- ____ % Prosthodontics, Removable
- ____ % Oral Surgery
- ____ % Cosmetic Dentristry
- ____ % TMJ/TMD
- ____ % Hospital Dentistry

8. Check the following dental techniques or procedures you perform. If none, so indicate.

- ☐ Sargenti, RC-2B, N2
- ☐ Acupuncture
- ☐ Radiation therapy
- ☐ Myomonitor
- ☐ Acupuncture
- ☐ Physical Therapy
- ☐ Tens Unit
- ☐ NONE of the above

9. Indicate the number of your employees:

a. Do you contract with nursing homes, health care providers or other group living facilities? ☐ Yes ☐ No
If yes, describe ______________________________

b. Do you contract with third party providers? ☐ Yes ☐ No

Name	Dates	Type of program

YOU MUST PROVIDE COPIES OF CONTRACTS, UNLESS THEY ARE "ON FILE" WITH BERKLEY RISK SERVICES

10. Indicate approximate percentage of your practice involving:
If NONE indicate.

	Office	Hospital
General Anesthesia	_____%	_____%
Nitrous Oxide/Oxygen Inhalation	_____%	_____%
Moderate Sedation	_____%	_____%
Minimal Sedation	_____%	_____%
Oral Premedication for anxiety and apprehension	_____%	_____%
None of the above.	_____%	_____%

11. Answer the following with regard to your office procedures:

a. Approximately how many patients do you examine or treat each working day?

b. How many hours do you work per week?

c. Do you personally take a health history of each patient? ☐ Yes ☐ No

d. Do you have the patient complete a health history? ☐ Yes ☐ No

e. Does your staff take a medical history of each patient? ☐ Yes ☐ No
Do you personally review if "yes" to (c.) or (d.) ☐ Yes ☐ No

f. If "yes" to (b.), (c.), or (d.), is that medical history updated? ☐ Yes ☐ No
If "yes" to (e.), how frequently?

g. When do you complete your patient charts?
- ☐ Immediately after treatment
- ☐ At the end of each day
- ☐ At the end of each w eek
- ☐ Other Describe: ______________________________

h. Do you record all phone calls regarding patient treatment in the patient's chart? ☐ Yes ☐ No

i. Do you use a written informed consent document in your office? ☐ Yes ☐ No
If yes, for what procedures? ______________________________

YOU MUST PROVIDE COPIES OF ALL INFORMED CONSENT DOCUMENTS USED.

j. Do you take a comprehensive x-ray survey as a part of your examination? ☐ Yes ☐ No

k. Do you provide a patient consultation of your treatment plan? ☐ Yes ☐ No

l. Do you record your detailed treatment plan in the patient chart? ☐ Yes ☐ No

12. Have you established emergency procedures, personnel and equipment to cope with patient emergencies, such as cardiac arrest, etc.? ☐ Yes ☐ No
Describe ______________________________

a. CPR Certification Date ____________________ Current? ☐ Yes ☐ No

13. Have you had any formal training in the use of nitrous oxide/oxygen inhalation?.. ☐ Yes ☐ No
Continuing Ed. _______ hrs. Dental School _______ hrs.
Intern/Residency _______ hrs. Other _______ hrs.

14. How many years have you used nitrous oxide?..

15. Have you had any formal training in the use of parenteral conscious sedative agents? .... ☐ Yes ☐ No
Continuing Ed. _______ hrs. Explain: ____________________
Intern/Residency _______ hrs.
Dental School _______ hrs.
Others _______ hrs.
How many years have you used parenteral conscious sedative agents? ____________________

16. Have you had any formal training in the use of enteral conscious sedative agents?.................................... ☐ Yes ☐ No
Continuing Ed. _______ hrs. Explain: ____________________
Intern/Residency _______ hrs.
Dental School _______ hrs.
Others _______ hrs.
How many years have you used enteral conscious sedative agents? ____________________

17. Have you had any formal training in the use of oral premedication/anxiolysis?... ☐ Yes ☐ No
Continuing Ed. _______ hrs. Dental School _______ hrs.
Intern/Residency _______ hrs. Others _______ hrs.
Explain ____________________

18. How many years have you used oral premedication/anxiolysis? ....

19. A. Describe your cosmetic dentistry education: ____________________
____

Continuing Ed. _______ hrs. Explain where: ____________________
Intern/Residency _______ hrs.
Dental School _______ hrs.
Others _______ hrs.

B. How many cases of cosmetic dentistry (full mouth cosmetic reconstruction, laminate veneers, 10+ veneers or crowns in one sitting, etc.) are done per month? _____________ cases

C. Do you utilize centric relation and anterior guidance?.. ☐ Yes ☐ No

D. Is a Myomonitor used in your neuromuscular analysis to establish the occlusion? .... ☐ Yes ☐ No

20. I answered questions numbered ____________________ on extra pages.

IF MORE SPACE IS NEEDED, PLEASE USE YOUR LETTERHEAD AS ADDITIONAL PAGES

____
____
____
____
____
____
____

Application for Professional Liability Coverage

I hereby declare and warrant that the statements set forth herein are true and that I have not withheld any information which is reasonably likely to influence the judgment of the company in considering this application for professional liability coverage. If the information supplied in this application changes between the date of the application and the effective date of insurance, I will, in order for the information to be accurate on the effective date of coverage, immediately notify Dentists Professional Liability Trust of Colorado of such changes, and recognize that the insurer may withdraw any outstanding quotations and/or authorizations or agreements to bind insurance coverage.

I hereby certify that I have reported all known claims and all known incidents which may become claims against my present insurance carriers, and have no knowledge of any threatened litigation or existing fact situations which could result in a claim being filed against me.

All written statements and materials furnished to the carrier in conjunction with this application are hereby incorporated by reference into this application and, along with the application, are made a part of any policy issued.

Date X______________________ Signature of Applicant X____

AUTHORIZATION

I grant, by way of this form, the right for the Dentists Professional Liability Trust of Colorado, or Berkley Risk Services of Colorado, or its agents, to obtain and disclose any information they require to evaluate this application and my continued participation in the Trust from:

1. any insurer or reinsurer
2. any state licensing board
3. any hospital or clinic
4. any peer review group
5. any state professional association
6. any consumer reporting agency

Date X______________________ Signature of Applicant X____

BRS Revised 7/08