



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
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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

Application for Professional Liability Coverage

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 _____ ~~Á~~ ~~XXXXXXXXXXXXXXXXXXXX~~ Degree _____ Year _____
If foreign dental school graduate, are you certified by the Educational Council for Dental School graduates? Yes No
If Yes, year of certification _____

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.

Application for Professional Liability Coverage

- 5.a. ~~AAA~~ 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 | _____ % Preventive Dentistry |
| _____ % Implantology <input type="checkbox"/> Surgical <input type="checkbox"/> Restorative/Reconstruction | _____ % Prosthodontics, Fixed |
| _____ % Pediatric Dentistry | _____ % Prosthodontics, Removable |
| _____ % Operative Dentistry | _____ % Oral Surgery |
| _____ % Orthodontics | _____ % Cosmetic Dentistry |
| _____ % Endodontics | _____ % TMJ/TMD |
| _____ % Periodontics | _____ % Hospital Dentistry |

8. Check the following dental techniques or procedures you perform. If none, so indicate.
- | | |
|--|--|
| <input type="checkbox"/> Sargenti, RC-2B, N2 | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Tens Unit |
| <input type="checkbox"/> Myomonitor | <input type="checkbox"/> NONE of the above |

Application for Professional Liability Coverage

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 week
 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

Application for Professional Liability Coverage

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 _____

Agreement to Maintain CDA Membership

NON PREMIUM AMENDMENT/ENDORSEMENT

issued by

Dentists Professional Liability Trust of Colorado

Amending and Endorsing Policy # _____ issued to
_____ providing coverage
from _____ to _____ as indicated below:

In consideration of the issuance of this coverage, the applicant agrees to apply to
and become a member of The Colorado Dental Association in
and maintain membership.

Signed: **X** _____ **X** _____
Date

All other terms and conditions of said policy remain unchanged by this Amendment/Endorsement.

IN WITNESS WHEREOF, The Trust has caused this Amendment/Endorsement to be signed by its
administrator.

BERKLEY RISK SERVICES OF COLORADO
Administrator

Dentists Professional Liability Trust of Colorado

Date: _____ By: _____

TRU-5(7-87)

SUPPLEMENTAL REPORT FORM

AS INDICATED IN QUESTION 5H OF THE APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE, THE FOLLOWING INFORMATION IS REQUIRED. COMPLETE A SEPARATE FORM FOR EACH **INCIDENT/CLAIM OR SUIT** REPORTED.

ONE OF THESE FORMS MUST BE COMPLETED FOR EACH LIABILITY, PEER REVIEW OR STATE BOARD COMPLAINT, CLAIM OR INCIDENT REGARDLESS OF THE DISPOSITION OF THE COMPLAINT, CLAIM OR INCIDENT.

PLEASE COPY THIS FORM IF YOU NEED TO REPORT MULTIPLE INCIDENTS/CLAIMS OR COMPLAINTS IF YOU HAVE HAD THEM.

IF NO INCIDENT/CLAIM OR SUIT, PLEASE INDICATE NONE, THEN DATE AND SIGN BELOW.

1. Name, age and sex of patient _____

2. Date of first examination _____

3. Dental condition and diagnosis at above date _____

4. Dates of treatment in question given; and nature of same _____

5. Date of incident/claim, and allegations made against you _____

6. Disposition of the incident/claim, amount of judgement or settlement _____

7. What insurance company, if any, was involved _____

8. Subsequent condition of health of patient _____

9. Name of other doctors, if any, involved in the incident/claim or suit _____

10. To whom may we refer for further information about the claim/suit _____

X _____
Date Completed Signature

X _____

**APPLICATION FOR RETROACTIVE COVERAGE
DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO**

IF COVERAGE IS NOT DESIRED, SIGN HERE X _____ **DATE X** _____

1. Name of Applicant _____ Date of Application _____
Business Address _____
City, State, Zip _____

2. Retroactive Date of Coverage Desired - Be exact by day
_____ to _____
Location of Previous Practice _____
Dates _____ to _____ to _____
Previously insured by _____ Dates _____ to _____

3. Did you practice as:
 Solo Group Corporation Partnership Contractee Other (specify) _____
Names of partners, members of corporation, professional association, employed or contractor (if applicable).

4. Did you have any potential claims, threats, comments or procedure problems that might indicate a potential claim?
(e.g.: Unsuccessful Root Canal)..... Yes No
Date: 1. _____ Type: 1. _____
2. _____ 2. _____
3. _____ 3. _____

Where are the patients now? (e.g.: moved, another office, etc.)
1. _____
2. _____
3. _____

Did you make any personal settlements? Yes No
Describe: 1. _____
2. _____
3. _____

Did you use a written release or statement? Yes No
1. _____
2. _____
3. _____

Was informed consent used? Yes No
1. _____
2. _____
3. _____

5. Have any Dentists contacted you about these patients or others? Yes No
Explain: _____

6. Provide the names and addresses of two dentists whom we can contact regarding your practice style, quality and manner in which you practiced during the period you desire to be covered for.

PLEASE COMPLETE AND RETURN, INCLUDING ANY OTHER INFORMATION YOU FEEL WE SHOULD INCLUDE IN OUR RECORDS.

ALSO, PLEASE INDICATE WHICH ADDRESS YOU WOULD PREFER YOUR MAIL BE DELIVERED TO.

Office Name _____

Office Address _____

Phone # _____

Office Fax # _____

Alternate Office Name _____

Alternate Office Address _____

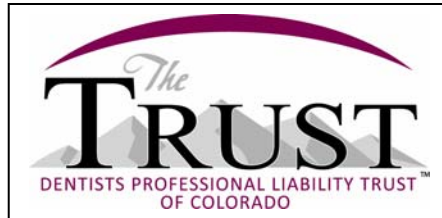
Phone # _____

Alternate Office Fax # _____

Home Address _____

Phone # _____

E-mail address _____



HIPAA BUSINESS ASSOCIATE CONTRACT

WHEREAS, the undersigned dentist ("Dentist") and/or any clinic in which said Dentist performs professional services is a "health care provider", and, therefore, a "covered entity" as those terms are defined in the Restated HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rules (45 C.F.R., Parts 160-164, hereinafter the "Privacy Rules");

WHEREAS, the Dentist has provided to current, or will provide to all new patients, or their duly authorized representatives, the "Notice" required under the Privacy Rules describing how medical information and/or protected health information ("PHI") may be used and disclosed and how patients can get access to that information as required by the Privacy Rules;

WHEREAS, the Privacy Rules define "business associate" to include a person or entity which assists the Dentist as a health care provider and covered entity in any function or activity described in the Privacy Rules which involves the use or disclosure of individually identifiable health information for such functions as, but not limited to, claims processing or administration, data analysis, utilization review, billing, benefit management or practice management or for an entity or person which provides legal, actuarial, accounting, consulting, management, administrative or other such functions.

WHEREAS, the Dentists Professional Liability Trust (of Colorado) ("Trust") provides professional liability coverage to the Dentist through the "Coverage Agreement" and the Dentist is a "Participant" in the Trust;

WHEREAS, the Trust is administered by the Dentist Professional Liability Benefit Plan, Inc. and its Board of Directors (the "Plan") or its contract administrator, Berkley Risk Administrators Company, LLC, d/b/a Berkley Risk Services of Colorado (hereinafter "BRS");

WHEREAS, the Trust, the Plan, BRS and their employees and agents are "business associates" to the Dentist and any clinic in which said Dentist performs professional services and need to be provided PHI from time to time to carry out their business associate functions;

WHEREAS, it is important to the Dentist that its business associates which may create or receive protected health information act to fully comply with HIPAA and the Privacy Rule requirements;

NOW, THEREFORE, in consideration of the terms and conditions hereinafter set forth, the Dentist, the Trust, the Plan and BRS, collectively referred to herein as the "Parties" agree as follows:

HIPAA BUSINESS ASSOCIATE CONTRACT

1. Permitted Uses and Disclosures.

The Trust, the Plan and BRS and their employees and agents, hereinafter collectively referred to as the "Business Associates" are permitted or required to use or disclose protected health information from the Dentist which the Dentist creates or receives from or related to the dental practice only as follows:

- a. The Business Associates are authorized and entitled to use the PHI for the necessary and proper management and administration of the Trust and the Coverage Agreement in which the Dentist is a Participant, including, expressly, but not necessarily limited to, any and all risk management functions; the defense of, handling of, and any other activities related to, any claim submitted by any patient or patient representative against the Dentist for which the Coverage Agreement provides coverage to the Dentist as a Participant in any judicial or administrative proceeding initiated against the Dentist as a Participant in the Trust and the Coverage Agreement; the handling of responses to administration of or other activities related to any dental incident or other incident or wrongful act alleged against the Dentist as a Participant in the Trust and which is covered as provided for by the Coverage Agreement; cooperation with the Trust in any and all of the Trust's representatives including defense counsel, claims administrators or expert witnesses related to the defense or settlement of any notice or claim or dental incident or wrongful act; the enforcement of any right of contribution of the Trust against any other person or entity who may be liable to the Dentist because of any damages to which the Coverage Agreement applies; assistance in securing and giving evidence and obtaining of witnesses in defense of any proceeding against the Dentist; the investigation, settlement or defense of any claim; and the assistance and cooperation with the Trust in the event any need exists in the judgment of the Trust to assist in or investigate any regulatory proceedings including, but not limited to, any such proceedings brought by the Colorado Board of Dental Examiners (subject to the express conditions and terms of the Coverage Agreement).
- b. The Business Associates may also use any such PHI related to the functions and activities set out in the prior paragraph in association with information they have and in their capacities as Business Associates with defense counsel, Trust and/or coverage counsel, or expert witnesses as required by the circumstances or such activities as set forth in the prior paragraph for which coverage is provided for under the Coverage Agreement.
- c. In the event that defense counsel, Trust and/or coverage counsel or expert witnesses need such PHI, the Business Associates or any of those who are involved in the issue at that time will obtain written and reasonable assurances from such person or organizations ("affiliated parties") to which the Business Associates or any of them are obligated to or will disclose such PHI to assure that the person, entity or organization will protect and hold such PHI in confidence and limit use or further disclosure only for the purposes for which the Business Associates have disclosed it as required by the Privacy Rules.

HIPAA BUSINESS ASSOCIATE CONTRACT

2. Prohibition on unauthorized use or disclosure.

The Business Associates and any of their affiliated parties as mentioned herein will neither use nor disclose PHI which they obtain or receive from the Dentist or the dental practice except as required and permitted by this contract, the Privacy Rules or as otherwise required by law.

3. Disclosures for Judicial and Administrative Proceedings.

The Dentist and the clinic may disclose such PHI and the Business Associates and any of employees or agents or their affiliated parties may disclose PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal provided, expressly, that such PHI is only such information as is expressly authorized by such order or is in response to a subpoena, discovery request or other lawful process provided:

- a. reasonable efforts are made to ensure the individual who the subject of the PHI is subject to the protection of a "Qualified Protective Order" as that term is defined and used in the Privacy Rules which, inter alia, prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested or obtained and the order requires the return to the Dentist or dental practice or the destruction of the PHI (including all copies made) that are not part of the court records at the end of the litigation or proceeding.

4. Exemption from Accounting of Disclosures of PHI.

The Parties understand and agree that the disclosures anticipated hereunder are exempt from the accounting required by the Privacy Rules, § 164.528 of 45 C.F.R. in that the disclosures anticipated and contemplated and to be transmitted hereunder are exempted under the provisions of the Privacy Rules exempting health care operations.

5. Inspections of Books and Records.

The Business Associates will, to the extent lawful, necessary and appropriate, make their internal practices, books and records available to the Dentist and to the Department of Health and Human Services whenever necessary during regular business hours and upon reasonable request, to determine compliance with 45 C.F.R., Parts 160-64 or this contract but shall not provide such information to other parties except as expressly required by order of law or legal process.

6. Breach of Obligations.

The Business Associates will report to the Dentist any use or disclosure of PHI which has not been permitted by this contract. Any report of such inappropriate disclosure or use will be made within 24 hours after any of the Business Associates learn of such non-permitted use or disclosure and will:

- a. identify the nature of the non-permitted, violating or use or disclosure;
- b. identify the PHI used or disclosed;
- c. identify who made the non-permitted or violating use or receive the non-permitted or violating disclosure;

HIPAA BUSINESS ASSOCIATE CONTRACT

- d. identify what corrective actions the Business Associates took or will take to prevent further non-permitted or violating uses or disclosures;
- e. identify what was done to mitigate any deleterious effect of the non-permitted or violating use or disclosure and;
- f. provide, as the Dentist or the dental practice may reasonably request, such other information including a written report as necessary.

7. Termination of Contract.

- a. This contract may be terminated by mutual agreement between the Parties.
- b. The Dentist may terminate this contract if the Dentist determines in his or her sole discretion that the Business Associates have breached any provision of this contract and will do so by providing written notice of termination stating the breach and effective date.
- c. In the event of termination of this agreement, cancellation, expiration or other conclusion of the contract, Business Associates will, if and to the extent feasible, return to the Dentist or destroy all PHI in whatever form it is contained. Such destruction or return of documents shall take place no later than 30 days after the effective date of the termination, cancellation, expiration or conclusion of this contract.
- d. The Business Associates will identify any such PHI created or received for or from the Dentist that cannot be feasibly returned or destroyed and will limit any further use or disclosure of such PHI or destroy such PHI. In the event of the return or destruction of any such PHI, the Business Associates will certify upon oath and in writing to the Dentist that such return or destruction has been completed and will deliver to the Dentist the identification of any PHI for which such return or destruction is infeasible and that for such PHI it will not use or disclose that information for any purposes.
- e. It's understood that the obligation to protect the privacy of the PHI created or received from the Dentist will be continuous and will survive termination, cancellation, expiration or any other conclusion of the contract.

8. ~~Amendment~~ Amendment• E

This contract may not be amended except by written agreement executed by the Parties. This contract will be amended in the event that there are required changes due to any amendments of the governing law or the Privacy Rules or in order to conform with any other obligations set forth in those Privacy Rules.

HIPAA BUSINESS ASSOCIATE CONTRACT

9. Applicable Law .

The terms and conditions of this contract shall be interpreted pursuant to Colorado law when state law is applicable and otherwise shall be subject to and interpreted under the applicable federal laws and, in particular, any applicable elements of the Privacy Rules or HIPAA.

IN WITNESS WHEREOF the Dentist and the Business Associates have executed this contract and duplicate originals to effective on the last date set forth below.


DENTISTS PROFESSIONAL LIABILITY TRUST
(of Colorado)

and

DENTISTS PROFESSIONAL LIABILITY BENEFIT PLAN, INC.

By:  July, 15 2009
Jeane L. Schoemaker, DDS, President Date

BERKLEY RISK ADMINISTRATORS COMPANY, LLC
d/b/a Berkley Risk Services of Colorado

By:  July 15, 2009
Nathan Reynolds, DDS Date
Manager of Administration

DENTIST

X _____

X _____
Date

PARTICIPATION AGREEMENT
for
DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO

THIS AGREEMENT, is entered by the undersigned "Participant" and The Dentists Professional Liability Benefit Plan, Inc., a Colorado corporation ("Trustee") as Trustee of The Dentists Professional Liability Trust dba Dentists Professional Liability Trust of Colorado ("Trust").

WHEREAS, the Participant, upon acceptance as a Participant in the Trust, is thereby entitled to purchase a professional liability policy upon such conditions as shall be determined from time to time by the Trustee.

NOW, THEREFORE, for and in consideration of the mutual promises herein contained, it is agreed as follows:

1. Participant acknowledges that he has received a copy of the Trust Agreement for Dentists Professional Liability Trust of Colorado (the "Trust Agreement") as revised (effective 4/13/99) and has reviewed its contents, including the provisions relating to termination of Participation. The Participant agrees to comply with all terms and conditions of the Trust Agreement, including any modifications thereof or supplements thereto, and any coverage agreement between the Trust and Participant, as well as any rules, regulations, eligibility requirements, and policies adopted by the Trustee from time to time; the provisions of all the foregoing, as amended from time to time are incorporated herein by this reference.

2. The Trustee agrees to provide Participant with professional liability coverage in such amounts and upon such conditions as Trustees shall prescribe from time to time, which coverage will be evidenced by a Coverage Agreement (Policy).

3. The Participant acknowledges that participation in the Trust and any professional liability coverage provided by the Trust are subject to termination as provided in the Trust Agreement, this Participation Agreement, or any professional liability Coverage Agreement provided by the Trustee.

4. Participant acknowledges that the purpose of participation in the Trust is to permit the Participant to purchase professional liability coverage, upon such terms and conditions as the Trustee shall establish. The Trust contributions paid by Participants for each policy year are intended to pay the cost of such professional liability coverage as may be issued by the Trust and to generate such reserves as the Trustee shall determine are advisable from time to time.

5. Participant agrees to pay all premiums when due for policies issued to him in accordance with rate schedules prepared by the Trustee from time to time.

6. Participant agrees to release to the Trustee all past and current information pertaining to underwriting, and claims by Participant's prior professional liability insurers, or their agents.

7. Participant agrees that termination or non-renewal of his participation in the Trust shall automatically terminate any coverage provided by the Trust to Participant; and that termination or non-renewal of any coverage provided by the Trust to Participant shall automatically terminate Participant's participation in the Trust. Upon termination or non-renewal of Participation in the Trust, any interest in the Trust assets to which Participant would otherwise be entitled will be forfeited; and the payment of such claims and other benefits as are provided in the Coverage Agreement or other agreement issued by the Trustee to Participant shall be the only continuing benefit to which Participant shall be entitled, the payment thereof to be subject to the provisions of such Coverage Agreement or other agreement.

PARTICIPATION AGREEMENT

8. In the event of the termination, merger or consolidation of the Trust, the Trust Assets may be transferred or disposed of in such manner as shall be determined by the Trustee in accordance with the Trust Agreement, as amended from time to time, and in accordance with the provisions hereof; provided, however, that only those persons who, at the time of such termination, merger or consolidation, are Participants of the Trust shall be deemed to have any interest in the Trust Assets. Participant understands and agrees that his interest in the Trust Assets shall be contingent in nature, and shall be subject to forfeiture as provided in paragraph 7 above.

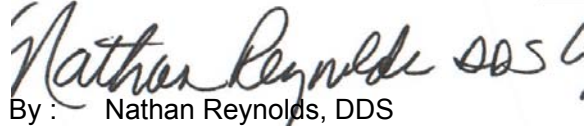
9. Participant recognizes that the Trust Agreement grants broad authority to the Trustee in operation and management of the Trust; and specifically grants broad authority for election and removal of the Trustee, and for reorganization or termination of the Trust to a voting majority of Participants. Participant agrees that in the event of any such merger, consolidation or reorganization of the Trust resulting in the creation of any successor entity, such a merger, consolidation, or reorganization shall not constitute a termination or any other event or change of circumstances which would require any distribution of assets of the Trust to Participants.

10. In the event of any conflict or inconsistency between the provisions of this Participation Agreement and those of the Trust Agreement, as amended from time to time, the provisions of the Trust Agreement, as amended, shall govern and control the rights and obligations of the parties hereunder.

IN WITNESS WHEREOF, the parties have affixed their signatures:

THE DENTISTS PROFESSIONAL
LIABILITY BENEFIT PLAN, INC.

Trustee:



By : Nathan Reynolds, DDS
Manager of Administration
Berkley Risk Services of Colorado

PARTICIPANT:

X _____

Date