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Dear Doctor,

Enclosed please find the application for Part Time coverage under the Dentists Professional Liability Trust of Colorado along with the criteria to qualify. Please review and complete the entire application.

The premium for the coverage is determined on a graduated reduction of the current base premium.

- A. Your practice must be limited to 16 hours per week of direct patient care or 64 aggregate hours per month of direct patient care.
- B. You must complete 20 hours of continuing education annually.

Should you have any questions regarding the coverage, please contact Janice at 303.357.2613 or Dr. Reynolds at 303.357.2604.

To qualify for a free tail endorsement when retiring, 5 years of continuous full time coverage are required. Two years of part time coverage are equivalent to one year of full time coverage for the purpose of calculating tail coverage.

Sincerely,

Nathan Reynolds, DDS
Dentists Professional Liability Trust of Colorado
Berkley Risk Services of Colorado

DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO

PART-TIME COVERAGE CRITERIA

1. **APPLICATION AND UNDERWRITING**
The application and underwriting process applies to any dentist requesting part-time coverage. The extent varies as to whether the dentist is a new applicant.
2. **HOURS ALLOWED**
 - A. 16 Hours per week of direct patient care.
 - B. 64 Hours per month aggregate hours.
3. **CONTINUING EDUCATION**
 - A. 20 Hours documented (Report Form) each year.
 - B. New graduates will be given academic credit for 10 hours and must complete and report 10 hours before the next renewal to complete the 20 hours.
4. **MONITORING THE WORK HOURS**
THE TRUST CAN MONITOR THE HOURS:
 - A. Mid-Year
 - B. Renewal
 - C. Claims Management
5. **RATE**
The rate is a graduated reduction of the current premium for that year. The exception is the new graduate who currently gets a first and second year reduction. The part-time rate could apply starting in the third year.
6. **TAIL OR EXTENDED REPORTING ENDORSEMENT**
The endorsement is based on a rate of 2X the part-time rate unless the dentist has qualified for the tail. Two part-time years of coverage will equal one full time year of coverage in determining qualification for a free tail after 5 consecutive years of coverage.
7. **CHANGES IN COVERAGE**
Two changes are allowed then the dentist remains in full-time coverage/premium.

SUPPLEMENTAL APPLICATION PART-TIME COVERAGE

Please complete and return to Berkley Risk Services of Colorado for underwriting.

I am applying for part-time coverage to replace my full time coverage.

Date Coverage is to be effective. _____

I understand I can only work 16 clinical hours per week or 64 clinical hours aggregate per month.

I will be providing the following services:

___ Examination, Diagnosis, Treatment Planning	___ Orthodontics
___ Preventive Dentistry	___ Operative Dentistry
___ Implantology (Surgical, Restorative/Reconstruction)	___ Cosmetic Dentistry
___ Prosthodontics, Fixed	___ Endodontics
___ Pediatric Dentistry	___ TMJ/TMD
___ Prosthodontics, Removable	___ Periodontics
___ Oral Surgery	___ Conscious Sedation

My continuing education is attached.

Signature: _____

Name: _____

Date: _____

Approved

Not Approved

Address: _____

Reasons: _____

By: _____

Date: _____

REPORT FORM

DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO

CONTINUING EDUCATION FOR PART-TIME COVERAGE

In accordance with the requirements governing part-time coverage, please submit the continuing education courses completed.

Continuing Education Requirements.

- A. Twenty (20) hours documented continuing education before coverage will begin. (Report Form)
- B. New graduates will be given academic credit for 10 hours and must complete and report 10 hours before coverage will begin.
- C. CDA continuing education hours may be used.

Attached is my CDA CE Report Form.

I am a new graduate applying for the first time.

Attached are my 20 hours.

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

Approved: _____ Signature _____

Not Approved: _____ Name _____
Reasons: _____ Address _____

By: _____

Date: _____ Date _____