

**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.  
\_\_\_\_\_  
\_\_\_\_\_

**APPLICATION FOR RETROACTIVE COVERAGE**

**AFFIDAVIT**

I, \_\_\_\_\_, practicing dentistry at: \_\_\_\_\_

Colorado do hereby certify that to the best of my knowledge I have no claims or pending claims nor do I know of any incidents which might lead to a claim relative to any of my professional services which have been rendered from \_\_\_\_\_ to \_\_\_\_\_.

I was insured with: \_\_\_\_\_  
and the expiration date is (was) \_\_\_\_\_.

With respect to providing you Extended Reporting Period coverage (i.e. "tail coverage") at no charge, The Coverage Agreement states:

"If the Participant dies or retires from the practice of dentistry after at least five (5) consecutive years of continuous coverage by the Trust, the Extended Reporting Period Endorsement will be provided with no additional contribution charge to the Participant or the Participant's estate."

I understand that the five consecutive years of continuous coverage referenced above must be satisfied with active coverage not the retroactive coverage review for which I have applied.

Certified:

BY: **X** \_\_\_\_\_  
Signature: \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

APPROVED:

DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO

By

TRU-8 (7-03)

