

**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.

