HALLMARK SPECIALTY INSURANCE COMPANY
HALLMARK NATIONAL INSURANCE COMPANY (OKLAHOMA)

DENTISTS AND ORAL SURGEONS MEDICAL PROFESSIONAL LIABILITY APPLICATION
CLAIMS MADE AND REPORTED COVERAGE

Please type or print all answers in ink. All questions require a response. If space is insufficient, please attach additional pages.

I General Information

A. Full name (include professional designation) ____

B. Residence Address ____
(Street Address) (City) (State) (County) (Zip Code)

Residence Phone #_______________SSN _________________ Date of Birth____________

C. Principal Practice Address ____
(Street Address)

____
(City) (State) (Zip Code) (County) (Post Office Box)

Additional Practice Locations_____________________________% of practice____________

____% of practice____________

____% of practice____________

Phone Number _________________________Fax Number __________________________

E-mail Address _________________________Web Site_____________________________

D. Are you a current U.S. citizen □ **Yes** □ **No**

E. Are you in current military service? □ **Yes** □ **No**

F. Type of Practice:

□ Unincorporated Solo Practice
□ Incorporated Solo Dentist
□ Professional Corporation
□ Professional Association
□ Limited Liability Company
□ Partnership
□ Other (Please explain) ____

Entity Name and Address ____

Do you require coverage for this entity? □ **Yes** □ **No** If "Yes", please provide the names of all physicians practicing under this entity:

Do you do any business under a d/b/a (doing business as)? □ **Yes** □ **No** If "Yes", please provide name: ____

G. Does your practice have:

A Blog?	□ **Yes**	□ **No**
An EHR (Electronic HealthCare Records) system?	□ **Yes**	□ **No**
Implemented procedures to comply with the HIPAA privacy rules?	□ **Yes**	□ **No**

H. Do you or any organization authorized by you engage in any advertising or solicitation of patients? □ **Yes** □ **No**
If "Yes", please attach copies of all advertising material including website address(es).

II Medical Training

Training	Hospital/School	City & State	Completed?	Dates From/To
Dental School			□ Yes □ No	
Internship			□ Yes □ No	
Residency			□ Yes □ No	
Additional Residency			□ Yes □ No	
Fellowship			□ Yes □ No	

A. Are you a Foreign Dental School Graduate? □ **Yes** □ **No**
If "Yes", please provide the date of ECFMG certification ______________________________

B. Are you currently certified by the American Dental Board □ **Yes** □ **No**
If "Yes", please provide Name of Board ____
Expiration date of Certification/Recertification ______________________________________
If "No", do you plan to take the Board examination? □ **Yes** □ **No**

C. Are you a member of any dental society? □ **Yes** □ **No** If "Yes", please list memberships:
____

D. How many hours of continuing education have you taken in each of the past two years?
____

III License Information

A. Please provide **Federal DEA License # and status** ____

B. Please provide the following information for all of the states in which you have practiced:

State	License #	Effective Date	Expiration Date	Active?
				□ Yes □ No
				□ Yes □ No

IV Office Staffing

A. Do you employ, contract with, or supervise any dentists? □ **Yes** □ **No**
If yes, provide the number and attach COI for each:_____________________________________

B. Do you employ, contract with or supervise any non-dental health care extenders?
If yes, enter information below

Type	# Employed	Coverage Desired?	# Contracted	Insured?
Dental Assistant				
Dental Technician				
Hygienists				

V Practice Characteristics

A. Please provide average weekly patient encounters including those patients seen by healthcare extenders you employ or supervise ______________________________________

B. Please provide average weekly practice hours ____

C. Are you in the employ or under contract to any entity (including governmental), other than the primary entity listed in **General Information**? □ **Yes** □ **No**

If "Yes", please provide details including your responsibilities:

If under any contracts, do they contain hold harmless agreements? □ **Yes** □ **No**

D. Do any of the following apply to your practice:

Administrative or teaching responsibilities □ **Yes** □ **No**

Moonlighting activities □ **Yes** □ **No**

Provide services for any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison or holding facility □ **Yes** □ **No**

If "Yes", to any of the above, please provide details:

E. Do you treat or consult in any sovereign nation other than the United States including American or Alaskan Native lands? □ **Yes** □ **No**

If "Yes", please explain: ____

F. Do you now or have you ever provided dental services to patients of a nursing home or resident of an assisted living facility? □ **Yes** □ **No**

(If yes, please describe)____

G. Do you wire jaws closed for the purpose of weight loss? □ **Yes** □ **No**

(if yes, # per year:______)

H. Do you use analgesia, sedation, or anesthesia on patients? □ **Yes** □ **No**

If yes, is this local only? □ **Yes** □ **No**

If you perform any of the following types of anesthesia, then complete the table; otherwise enter "N/A"

	Inhalation Conscious	**Oral Conscious**	**Parenteral Conscious**	**Parenteral Deep Sedation**	**General Anesthesia**
% of patients under age 18					
Drugs used					
Office, Surgi-Center or Hospital Setting					
Administered by: You, Oral Surgeon, Physician Anesthesiologist, Dentist Anesthesiologist, CRNA, RN/LPL, Other (specify)					

K. Which of the following emergency treatment items do you have available?

____ Oral airway ____ Ambu bag ____ Endotracheal tubes/scopes

____ Oxygen ____ Emergency drugs ____ None available

VI Practice Information

A. If you have performed any implant procedures within the last year, then answer the following:

I have not performed any implant procedures within the last year: _____(initial)

1.Osseointegration only ____ # procedures

2.Endosteal - Ramus Frame ____ # procedures

3.Endosteal – Other ____ # procedures

4.Subperiosteal (above bone but beneath gum) ____ # procedures

5.Transosseus (penetrate entire jaw) ____ # procedures

6.Other ____ ____ # procedures

7. Do you perform sinus lifts or other surgical procedure In conjunction with implant procedures? □ **Yes** □ **No**

B. Provide the approximate percentage of your practice in the following:

Practice Area	%	Practice Area	%
Bone Grafting	___%	Microneurosurgical Procedures	___%
Cosmetic Dentistry		Oral Pathology	___%
Bonding	___%	Oral Radiology	___%
Enamel Shaping	___%	Orthodontics	___%
Full Mouth Restoration	___%	Orthognathic Procedures	___%
Veneers	___%	Pediatric Dentistry	___%
Whitening with Lasers	___%	Periodontics	___%
Other Procedures:	___%	Prosthodontics	___%
____________________		Prosthetics	
Non-Dental Cosmetic Procedures (Botox, Collagen, fillers, etc)		Fixed	___%
________________________	___%	Removable	___%
Endodontics		Sleep Apnea	___%
Single Rooted	___%	Surgery	___%
Multi Rooted	___%	Therapy	___%
Sargenti Root Canal Method	___%	Surgery	
General Dentistry		Facial – Elective Cosmetic	___%
Extractions of Impacted Teeth	___%	Head and Neck	___%
Oral Surgery		Oral/Maxillofacial	___%
__________________	___%	Outside Oral/maxillofacial region	
Root Canal	___%	_____________________	___%
Simple Extractions Only	___%	TMJ	
Implants		Non-Surgical	___%
Restoration	___%	Surgical	___%
Placement	___%	Other _______________	___%
		Total	**100%**

C. Check all Procedures/Treatments that you perform and indicate where:

Procedure	Office	Hospital	Other
Biopsies	_____	______	_____
Blepharoplasty	_____	______	_____
Cheek Implant	_____	______	_____
Chin Surgery	_____	______	_____
Cleft Lip or Palate Surgery	_____	______	_____
Cosmetic Procedures			
Botox Injections	_____	______	_____
Chemical Peels	_____	______	_____
Chemobrasion	_____	______	_____
Collagen Injection	_____	______	_____
Dermabrasion	_____	______	_____
Face Lift	_____	______	_____
Laser Skin Resurfacing	_____	______	_____
Other Laser Procedure (Specify:_____________)	_____	______	_____
Lippodissolve	_____	______	_____
Microdermabrasion	_____	______	_____
Silicone Injection	_____	______	_____
Other: _________________________________	_____	______	_____
Liposuction	_____	______	_____
Oral/Maxillofacial Surgery	_____	______	_____
Rhinoplasty	_____	______	_____
Sargenti root canal method	_____	______	_____
Sinus Lift TMJ	_____	______	_____
Surgery	_____	______	_____
Uvulopalatoplasty	_____	______	_____
Other: ________________________	_____	______	_____
Other: ________________________	_____	______	_____
I do not perform any of the above procedures/treaments		Initial:	_____

VII Coverage Information

A. Coverage Desired:
a. ___Claims Made coverage without Prior Acts (RDI)
b. ___Claims Made coverage with Prior Acts coverage

B. If claims made coverage without Prior acts coverage was selected as the desired coverage, and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:
a. ____An extended reporting endorsement (tail coverage) has been or will be purchased.
b. ____An extended reporting endorsement has not and will not be purchased.

C. Requested Coverage Period
a. From (Date) _____/_____/________(Year)
b. To (Date) _____/_____/_________(Year)

D. The Retroactive date shown on your current claims made policy is:
a. ______/_____/______(Year)

E. Limits of Liability being requested:
___100/300 ___500/1500
___200/600 ___1M/3M
___250/750 ___Other (specify) ______________

F. Please provide the following information regarding the past 5 years of professional liability coverage:

Policy Period	Insurer	Policy Limits	Deductible	Policy Type	Premium	* Total # of Claims
				□ CM □ Occ		
				□ CM □ Occ		
				□ CM □ Occ		
				□ CM □ Occ		
				□ CM □ Occ		

**** Total # of claims by carrier regardless of payment, no payment, dismissed or open.***

G. Have you ever practiced without professional liability insurance? □ **Yes** □ **No**
If "Yes", please indicate dates: From____________________ To _______________________

H. Have you ever had insurance company decline, cancel, rescind or non-renew any Professional Liability policy? (Response not required in State of Missouri.) □ **Yes** □ **No**
If "Yes", please provide explanation:

I. Please complete the following:

1. Have you had or been involved now or ever in a professional liability claim or suit? □ **Yes** □ **No**
If "Yes", please complete the **Supplemental Claim Information** form for each.

2. Have you had any losses or claims that have not been reported to a prior insurance carrier or any other source from which payment could be made? □ **Yes** □ **No**

3. Are you aware of any specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim that has not been reported to a prior insurance carrier? □ **Yes** □ **No**

4. Have you had any requests for Dental records by a patient or his/her attorney which might result in a claim? ☐ **Yes** ☐ **No**

5. Do you have any information relating to service(s) on a Board which may result in a claim? ☐ **Yes** ☐ **No**

6. Have you had any prior professional liability carrier refuse coverage for, or decline to accept a report of a specific act, omission or circumstance involving a particular and specific professional service(s) that may result in a claim, threat of a claim, letter of intent, adverse result notice or attorney contact? ☐ **Yes** ☐ **No**

7. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought Dental Board to deny, limit, suspend non-renew or revoke your privileges? ☐ **Yes** ☐ **No**

8. Has your license to practice Dentistry or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ☐ **Yes** ☐ **No**

9. Have you ever been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ☐ **Yes** ☐ **No**

10. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance, other than minor traffic violations? ☐ **Yes** ☐ **No**

11. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse? If "Yes", complete the **Substance Abuse Supplement.** ☐ **Yes** ☐ **No**

12. Have you ever been evaluated, treated or hospitalized for mental or emotional disorders? ☐ **Yes** ☐ **No**

13. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation would limit your ability to safely practice Dentistry? ☐ **Yes** ☐ **No**

If "Yes" to any of the above, please provide details:

VIII Notice to the Applicant – Please Read Carefully

If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy.

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom, shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is assigned and the effective date of the policy, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

The policy for which application is made applies only to "Claims" first made during the "Policy Period".

Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy.

Unless amended by endorsement, "Claim Expenses" shall be applied against the "Deductible".

IX FRAUD WARNING

Applicable in AL, AR, DC, LA, MD, NM, RI and WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*.
*Applies in FL Only.

Applicable in KS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*.
*Applies in NY Only.

Applicable in ME, TN, VA and WA
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits.
*Applies in ME Only.

Applicable in NJ
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years

X Warranty

I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy, I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

_______________________________ _______________________

Name of Applicant Title

_______________________________ _______________________

Signature of Applicant Date

Signing this form does not bind the Applicant or the Company to complete the Insurance.

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

HALLMARK SPECIALTY INSURANCE COMPANY

CLAIM INFORMATION

PHYSICIANS & SURGEONS CLAIMS MADE COVERAGE

Please complete as follows:

- **Answer all questions. State not applicable to those that do not apply,**
- **Print in ink, and**
- **Sign and date by applicant.**

APPLICANT'S NAME: ____

CLAIMANT'S NAME: ____

DATE OF ALLEGED INCIDENT:______________**DATE CLAIM WAS MADE:**__________________

STATUS OF CLAIM:

Dismissed ____Abandoned ____Won by Defense ____Won by Claimant _____Open______

If **Won by Claimant**, answer the following: Court Judgment ________Settlement __________

Total $ paid ___________________ Total $ paid on your behalf ________________________

If **Open**, Settlement Demand ___________ Defendant's Settlement Offer ________________

Insurer's current loss reserve ______________ Name of Insurer________________________

DESCRIPTION OF CLAIM: (Include all services leading up to the claim and any other relevant information.)

I understand all information provided in this document becomes part of my Professional Liability Application for coverage, and as such it is subject to the same conditions and warranty of said application.

____ ______________________________________

NAME OF APPLICANT (Please print) **DATE**

____

SIGNATURE OF APPLICANT

Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.