



3. YOUR PRACTICE (CONTD.)	4. PROCEDURES
<p>c. States in which you are registered and licensed to practice:</p> <p>State _____ License # _____</p> <p>_____</p> <p>_____</p>	<p>a. Do you perform: <span style="float: right;">Yes No</span></p> <p>(i) Orthodontics? <span style="float: right;">[ ] [ ]</span></p> <p>(ii) Extractions of impacted teeth? <span style="float: right;">[ ] [ ]</span></p> <p>(iii) Root canals? <span style="float: right;">[ ] [ ]</span></p> <p>(iv) Implants? <span style="float: right;">[ ] [ ]</span></p> <p>(v) Oral surgery or assisting in oral surgery? <span style="float: right;">[ ] [ ]</span></p> <p>(Describe) _____</p>
<p>d. Where have you practiced your profession since residency?</p> <p>In _____ during the years _____</p> <p>In _____ during the years _____</p> <p>In _____ during the years _____</p>	<p>b. Do you administer analgesia? <span style="float: right;">[ ] [ ]</span></p> <p>If Yes, please list types of analgesia used:</p>
<p>e. Dental Specialty (CHECK ONE)</p> <p>[ ] General Dental Practice <span style="margin-left: 150px;">[ ] Orthodontics</span></p> <p>[ ] Oral Surgery <span style="margin-left: 150px;">[ ] Anesthesiology</span></p> <p>[ ] Other (describe) _____</p>	<p>c. (i) Do you or an employee of yours administer general anesthesia? <span style="float: right;">[ ] [ ]</span></p> <p>If Yes, answer (ii) and (iii) below.</p> <p>(ii) Is the general anesthesia administered:</p> <p>1. In a dental office? <span style="float: right;">[ ] [ ]</span></p> <p>2. In a hospital? <span style="float: right;">[ ] [ ]</span></p> <p>3. In another type of facility? <span style="float: right;">[ ] [ ]</span></p> <p>If Yes, please attach explanation.</p> <p>(iii) Please list types of general anesthesia used: _____</p>
<p>f. Do you have any other professional specialty? <span style="float: right;">[ ] Yes [ ] No</span></p> <p>If Yes, please describe</p>	
<p>g. Do you anticipate taking any additional residencies or changing your specialty <span style="float: right;">[ ] Yes [ ] No</span></p> <p>If Yes, please attach explanation.</p>	
<p>h. Approximate number of patient encounters ANNUALLY: _____</p> <p>Approximate number of hours worked weekly: _____</p>	
<p>i. Approximate gross annual income from the practice (check one):</p> <p>[ ] less than 20,000 <span style="margin-left: 150px;">[ ] 80,000 to 99,000</span></p> <p>[ ] 160,000 to 179,999 <span style="margin-left: 150px;">[ ] 20,000 to 39,999</span></p> <p>[ ] 100,000 to 119,999 <span style="margin-left: 150px;">[ ] 180,000 to 199,999</span></p> <p>[ ] 40,000 to 59,000 <span style="margin-left: 150px;">[ ] 120,000 to 139,999</span></p> <p>[ ] 200,000 or more [ ] 60,000 to 79,999</p> <p>[ ] 140,000 to 159,999 please estimate _____</p>	<p>d. Do you administer general anesthesia to patients of other dentists? <span style="float: right;">[ ] [ ]</span></p> <p>If yes, please explain.</p>





**7. CLAIMS/HISTORY (CONTD.)**

g. Please list professional liability insurance for each of the past four years (IF NONE, STATE NONE).

<u>Insurance Co.</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible (if any)</u>	<u>Premium</u>	<u>Inception Mo./Day/Yr.</u>	<u>Exp Mo./Day/Yr.</u>	<u>Expiration Mo./Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retroactive Date</u>
								<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____

h. Has any insurance company or Lloyd's ever canceled, declined, refused to renew or accepted your malpractice insurance only on special terms? [ ] Yes [ ] No

If Yes, please give details.

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, 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 of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.