Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

DENTISTS & ORAL SURGEONS NEW BUSINESS APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of your business letterhead
  - Copy of all advertising that you use
  - Copy of all reporting endorsements previously issued to you
  - 5-year company loss runs, valued within the last 60 days

PERSONAL INFORMATION

Applicant's Name: ______________________________ Date of Birth: ______________

Social Security Number: ______________________________ Home Phone: ______________

Professional Designation: ____

Home Address: ____

____

City County State Zip

Are you a U.S. Citizen? Yes ☐ No ☐ If no, indicated status and date of entry ______________

Provide the following information for all states in which you are licensed to practice:

State	% of Practice	License #	Active/Inactive/Temporary/Pending

Federal DEA License Number and Status: ____

Current Practice Specialty: ______________________________ % of Practice: ______________

Subspecialty: ______________________________ % of Practice: ______________

Board Certification

Board Certified by: ______________________ Board Eligible-Date of Exam: ______________

OFFICE INFORMATION

Principal Office Address: ______________________________

____
City County State Zip

Mailing Address: ______________________________

____
City County State Zip

Phone: ______________ Fax: ______________

Email: ______________ Website: www.______________

Secondary Office Locations (if any): ______________________________

____

____

DENTAL TRAINING & EDUCATION

1. Date you began practicing dentistry: ______________________________

Complete the following:

	Institution	Location	Degree/Specialty	Completed Y/N	From	To
Dental School						
Internship						
Residency						
Additional Residency						
Fellowship						

2. Are you a Foreign Dental School Graduate? Yes ☐ No ☐ If yes, date began practicing in U.S.: ______________

Indicate number of CE hours you have completed in past two years: ______________

3. Are you a member of any dental or professional association? If yes, please list: ______________

____

PRACTICE INFORMATION

4. List all locations and dates where you have practiced in the last 10 years:

Practice Name	City/State	Specialty	From	To

5. Applicant is an: ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership

☐ Employed Dentist By whom ______________________________

Other (describe): ______________________________

6. Practice is a: ☐ Solo Practice ☐ Group Practice
Entity Name: ______________________________ Applicant's % Ownership: _____%

7. How many other dentists practice at this entity? ____

8. Are you requesting that the entity be named on your policy? Yes ☐ No ☐
If yes, please forward articles of incorporation.

9. Do you practice with any dentists not named above? Yes ☐ No ☐
If yes, please provide each name and practice relationship: _______________________________
____

10. Are you employed full-time or part-time by the federal, state, or local government, or are you on active military duty? If yes, please explain: ______________________________________ Yes ☐ No ☐

Professional / Legal / Administrative Actions against you:

11. Has your dental or narcotics license been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? If yes, please explain: ______________________________________
____
____

12. Has your board certification or membership in any dental society or associate been refused, suspended, revoked, or voluntarily surrendered? (Please explain) ____
____

13. Have your hospital privileges been suspended, restricted, denied, placed in probation status, or revoked? (Please explain) ____
____

14. Have you been charged with or convicted of a crime other than minor traffic violations? (Please explain) __________
____

15. Have you been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? (Please explain) ____
____

16. Has any fee or professional relations complaints been registered against you with your dental association, hospital, or a state licensing authority? (Please explain) ______________________________________
____

OFFICE STAFF

17. Do you employ, contract with, or supervise any dentists? Yes ☐ No ☐
If yes, provide the number and attach COI for each: ____________________________________

18. Do you share office space or have an expense sharing arrangement with any other dentist other than those named above? If yes, provide the number and attach COI for each: ______________________ Yes ☐ No ☐

19. Do you employ, contract with or supervise any non-dental health care extenders? If yes, enter information below: Yes ☐ No ☐

Type	# Employed	Coverage Desired? Y/N	# Contracted	Insured? Y/N
Dental Assistant				
Dental Technician				
Hygienists				
Physician*				
Physician Assistant				
Surgeon Assistant				
CRNA				
Lab/X-Ray Technician				
Nurse (RN, LPN, LVN)				
Other				

* If coverage is desired, please complete a separate application for each

SPECIFICS OF PRACTICE/PROCEDURES

20. Have there been any changes in your specialty or practice activities within the past 10 years? Yes ☐ No ☐
(If yes, explain) ______________________

21. Do you anticipate any changes in your specialty or practice activities in the next year? Yes ☐ No ☐
(If yes, explain) ______________________

22. Do you perform any procedure not routinely performed by others practicing in your specialty or subspecialty? (If yes, explain) ______________________ Yes ☐ No ☐

23. Provide the following information for all hospitals and surgery-centers where you are currently on staff:
(If no hospital privileges, attach protocol for patient admission)

Name of Facility	City	State	% of Work	Type of Privileges

24. Average weekly patient encounters:__________
25. Average weekly practice hours:__________
26. Approximate gross annual income from your practice: $____________

27. Do you now or have you ever provided dental services to patients of a nursing home or residents of an assisted living facility? (If yes, please describe) ______________________ Yes ☐ No ☐

28. Do you work for any Locum Tenens companies as an employee or independent contractor? Yes ☐ No ☐
(If yes, indicate number of hours worked each month:________ AND does the Locum Tenens company provide you with Professional Liability insurance? If yes, provide copy of the COI)

29. Do you now or have you ever provided services to any federal, state, or local jail, prison, or correctional facility? (If yes, describe) ________________________________ Yes ☐ No ☐

____

30. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? (If yes, describe) ________________________________ Yes ☐ No ☐

____

31. Do you wire jaws closed for the purpose of weight loss? (if yes, # per year:______) Yes ☐ No ☐

32. Do you endorse any products or participate in any activity which offers professional advice to the public, including but not limited to newspaper columns and broadcasts? (if yes, describe) ________________ Yes ☐ No ☐

____

33. Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering dental services? (If yes, indicate which states and how much each represents as a percent of your practice) ________________ Yes ☐ No ☐

____

34. Do you use analgesia, sedation, or anesthesia on patients? Yes ☐ No ☐
If local only, check here ☐

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)					

35. Do you adhere to the Harvard Standards for anesthesia administration? Yes ☐ No ☐

36. Do you hold an ACLS certificate? Yes ☐ No ☐

37. Which of the following emergency treatment items to you have available?

____ Oral airway ____ Ambu bag ____ Endotracheal tubes/scopes
____ Oxygen ____ Emergency drugs ____ None available

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

Bone Grafting ____%
Cosmetic Dentistry
- Bonding ____%
- Enamel Shaping ____%
- Full Mouth Restoration ____%
- Veneers ____%
- Whitening with Lasers ____%
- Other Procedures ____%
- ____________________________

Non-Dental Cosmetic Procedures (Botox,
- Collagen, fillers, etc)___________________
- ____________________ ____%

Endodontics
- Single Rooted ____%
- Multi Rooted ____%
- Sargenti Root Canal Method ____%

General Dentistry
- Extractions of Impacted Teeth ____%
- Oral Surgery__________________________
- _________________________ ____%
- Root Canal ____%
- Simple Extractions Only ____%

Implants
- Restoration ____%
- Placement ____%

Microneurosurgical Procedures ____%
Oral Pathology ____%
Oral Radiology ____%
Orthodontics ____%
Orthognathic Procedures ____%
Pediatric Dentistry ____%
Periodontics ____%
Prosthodontics ____%
Prosthetics
- Fixed ____%
- Removable ____%
- Sleep Apnea ____%
- Surgery ____%
- Therapy ____%

Surgery
- Facial – Elective Cosmetic ____%
- Head and Neck ____%
- Oral/Maxillofacial ____%
- Outside oral/maxillofacial region
- ____________________ ____%

TMJ
- Non-surgical ____%
- Surgical ____%

Other _______________________ ____%
Other_______________________ ____%
TOTAL **100%**

39. 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

40. 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	_____	_____	_____

Procedure	Office	Hospital	Other
Cosmetic Procedures			
Botox Injection	_____	_____	_____
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/treatments		Initial:	_____

PRIOR POLICY AND LOSS INFORMATION

41. Provide the following information pertaining to your past 7 years of professional liability insurance coverage:

Policy Period	Carrier	Policy Limits	Deductible	Claims Made or Occurrence?	Retro Date	Premium

42. Have you ever practiced without professional liability insurance? Yes ☐ No ☐
(If yes, specify dates) ____

43. Do you have professional liability insurance for work you do elsewhere? Yes ☐ No ☐
If yes, provide detail) ____

44. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? (If yes, provide detail) ______________________________ Yes ☐ No ☐
____

45. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? (If yes, Supplemental Claim Information must be completed for each claim) Yes ☐ No ☐

46. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? (If yes, explain) ________________________________ Yes ☐ No ☐

____

47. Are you aware of any request for dental records by a patient or his/her attorney which might result in a claim? (If yes, explain) ________________________________ Yes ☐ No ☐

____

48. Are you aware of any information relating to services on a Board which might result in a claim? Yes ☐ No ☐
(If yes, explain)____

49. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? (If yes, explain) Yes ☐ No ☐

50. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? Yes ☐ No ☐ N/A ☐

If yes, how many? _______________
If no, explain details on the Supplemental Claim Information

REQUESTED COVERAGE

(NOTE: The Company may not offer or quote requested coverage)

Requested Effective Date:_____________

Requested Retroactive Date:_______________

Requested Limits of Liability

___ $100,000/$300,000
___ $200,000/$600,000
___ $250,000/$750,000
___ $500,000/$1,500,000
___ $1,000,000/$3,000,000
___ Other $____________

Requested Deductible

___ $2,500
___ $5,000
___ $7,500
___ $10,000
___ $25,000
___ Other $____________

SUPPLEMENTAL INFORMATION

(Use this space to provide additional information or to answer any question)
Question # and additional information

____
____
____
____
____
____
____
____
____
____
____
____

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: ____ Title: _______________________________

FEIN #: ____

Applicants Signature: ____ Date: _______________________________

Agent/Broker Name: ____

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, then please photocopy this form and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: ____ Age:______ Sex:_______

Date reported to insurance company: ____

Name of insurance company: ____

Date of incident and your treatment: ____

Allegations: ____

____

____

____

Additional Defendants: ____

What is the present condition of the patient? ____

____

Status of Claim

___Suit threatened, no action taken	Court outcome in your favor:	Unresolved/Open
___Suit filed but dropped by claimant	___Jury verdict	___Awaiting mediation
___Summary judgment in your favor	___Directed verdict	___Awaiting court action
___Suit settled out of court	Court outcome in favor of plaintiff:	Reserve amount:
a. Date claim paid:___________	___Jury verdict	$_________________
b. Amount paid:$____________	___Directed verdict	
c. Did you want to settle? Yes ☐ No ☐	Amount of loss payment: $____________________	

Name and address of the attorney assigned to your case: ____

____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim: ______________________

____

____

____

Signature: ____ Date: ____________________________

Printed Name: ____________________________________