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

DENTISTS & ORAL SURGEONS RENEWAL 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 renewal 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 Curriculum Vitae and letterhead IF CHANGED IN THE PAST 12 MONTHS.
- Current loss runs from a prior insurance company, IF ANY OF THE FOLLOWING APPLIES:
  - There was an open claim, suit or incident pending with a prior insurance company;
  - An Extended Reporting Period (ERP) Endorsement was purchased from a prior insurance carrier within the past 5 years;
  - Coverage was written on an occurrence basis by the insurance company within the past 5 years.
- A Claim Supplemental Form or comprehensive narrative on your letterhead must be completed for each claim resolved/closed or a new claim made, incident surfacing and/or suit brought against you IN THE PAST 12 MONTHS that has not already been reported to Kinsale Insurance Company.

PERSONAL INFORMATION

Applicant's Name and Professional Designation: _____

Business Entity Name:_____

Practice Address: _____
STREET CITY COUNTY STATE ZIP

Mailing Address: _____
STREET CITY COUNTY STATE ZIP

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

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

PRACTICE SPECIALTY

1. Current Practice Specialty: _____ % of Practice: _____
Subspecialty: _____ % of Practice: _____

2. Do you limit your practice to the above Specialty and/or Sub-Specialty? ☐ YES ☐ NO
If NO, please explain: _____

3. Have you added or discontinued procedures which are considered to be outside of, or not usual to the above practice specialty, or are experimental in nature within the past year, or do you anticipate doing so in the near future? ☐ YES ☐ NO
If YES, please list procedures/services and note dates of change(s): _____

4. Have you changed your dental specialty within the past year or do you anticipate doing so in the near future? ☐ YES ☐ NO
If YES, please explain: _____

5. Indicate number of CE hours you have completed in past two years: _____

OFFICE STAFF

6. Do you employ, contract with, or supervise any dentists? ☐ YES ☐ NO
If yes, provide the number and attach COI for each:_____

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

8. Do you employ, contract with or supervise any non-dental health care extenders? ☐ YES ☐ NO

If yes, complete the table below

Type	#Employed	Coverage Desired	# Contracted	Insured?
Dental Assistant		Yes ☐ No ☐		Yes ☐ No ☐
Dental Technician		Yes ☐ No ☐		Yes ☐ No ☐
Hygienists		Yes ☐ No ☐		Yes ☐ No ☐
Physician*		Yes ☐ No ☐		Yes ☐ No ☐
Physician Assistant		Yes ☐ No ☐		Yes ☐ No ☐
Surgeon Assistant		Yes ☐ No ☐		Yes ☐ No ☐
CRNA		Yes ☐ No ☐		Yes ☐ No ☐
Nurse (RN, LPN, LVN)		Yes ☐ No ☐		Yes ☐ No ☐
X-Ray Technician		Yes ☐ No ☐		Yes ☐ No ☐
Other		Yes ☐ No ☐		Yes ☐ No ☐

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

SPECIFICS OF PRACTICE/PROCEDURES

9. Average Weekly Practice Hours: _____

10. Average Weekly Patient Encounters: _____

11. Do you use analgesia, sedation, or anesthesia on patients? ☐ 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:					

12. 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%**

13. 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

14. 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 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:	_____

15. In the past 12 months:

a. Has any State/Dental Board refused you a dental license? ☐ YES ☐ NO
b. Has any State/Dental Board restricted, suspended or revoked your dental license? ☐ YES ☐ NO
c. Has any State/Dental Board imposed a fine or any other obligation? ☐ YES ☐ NO
d. Has any State/Dental Board issued a letter of guidance or public reprimand? ☐ YES ☐ NO
e. Have you voluntarily surrendered a medical license? ☐ YES ☐ NO
f. Has any State/Dental Board placed you on probation or restricted your practice? ☐ YES ☐ NO
g. Is your dental license currently under investigation for any reason in any state? ☐ YES ☐ NO
h. Has your Narcotics/DEA license been surrendered/refused/suspended/revoked (voluntarily or otherwise)? ☐ YES ☐ NO
i. Has there been any professional conduct or fee complaint filed against you with any Specialty, National, State or County Dental Society, other Professional Association or any licensing or regulatory authority? ☐ YES ☐ NO

If YES to any of the above, describe the circumstances, outcome, dates on Page 5 and attach copies of any relevant documents.

16. In the past 12 months:

a. Have you become American Board Certified? ☐ YES ☐ NO
b. Has your Board Certification or membership in any dental association/society been refused, suspended, revoked or voluntarily surrendered? ☐ YES ☐ NO

17. In the past 12 months:

a. Have you been evaluated, treated, or recommended for treatment of alcohol, narcotics, or any other substance abuse, sexual addiction, or mental illness? ☐ YES ☐ NO

b. Have you been diagnosed with, or treated for, a chronic physical illness and/or disability? ☐ YES ☐ NO

c. Have you become aware of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice dentistry now or anytime in the future? ☐ YES ☐ NO

IF YES to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents (including a letter from your treating physician addressing your state of health and whether such condition could adversely affect your ability to practice medicine).

18. IN THE PAST 12 MONTHS, have you been charged with or convicted of a felony or misdemeanor for anything other than a minor traffic violation? ☐ YES ☐ NO ***IF YES, describe circumstances, outcome, dates and attach any relevant documents.*** _____

_____

_____

19. IN THE PAST 12 MONTHS, have your hospital privileges been suspended, denied, revoked, restricted, or otherwise sanctioned? ☐ YES ☐ NO ***IF YES, describe circumstances, outcome, dates and attach any relevant documents.*** _____

_____

_____

20. Are you aware of any request for dental records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO ***If YES, please complete Supplemental Claims Information on Page 7.***

21. 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? ☐ YES ☐ NO ***If YES, describe circumstances, outcome, dates and attach any relevant documents.*** _____

_____

_____

22. 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 **Indicate N/A if you are not aware of any such circumstances**. If yes, how many? _____ ***Please complete a supplemental claims form for each.***

SUPPLEMENTAL INFORMATION

Use this page to as needed to address questions referenced within the application or to provide information you deem pertinent to our review of your application

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

- I have no known losses or claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;
- I have no knowledge of acts, omissions or circumstances that relate to a professional service which could reasonably result in a claim, that has not been reported to a prior insurance carrier;
- I have no knowledge of any request for medical records by a patient or their attorney which might result in a claim;
- I have no knowledge or information relating to service or services on a Board which might result in a claim; and
- I have no knowledge 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, or attorney contact.

My signature below confirms the above statements

CONSENT, WARRANTY, REPRESENTATIONS and ACKNOWLEDGMENT of UNDERSTANDING FRAUD WARNING

Any person who knowingly, and with the intent to defraud any insurance company or other person, includes any false or misleading information in an application for insurance or statement of claim commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

The applicant declares that the information contained herein is accurate and that no material facts have been suppressed. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature: _____ Date:_____

Printed 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
___Suit filed but dropped by claimant
___Summary judgment in your favor

___Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
c. Did you want to settle? Yes ☐ No ☐

Court outcome in your favor:
___Jury verdict
___Directed verdict

Court outcome in favor of plaintiff:
___Jury verdict
___Directed verdict
Amount of loss payment: $_____

Unresolved/Open
___Awaiting mediation
___Awaiting court action

Reserve amount:
$_____

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: _____