ace usa

New York – Application for Claims-Made Dental Professional Liability Insurance

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY.

This policy provides no coverage for claims arising out of dental incidents which take place prior to the retroactive date stated in this policy. This policy covers only claims actually made against the insured while the policy remains in effect and all coverage under this policy ceases upon termination, except for the automatic extended reporting period coverage, unless the insured purchases unlimited additional extended reporting period coverage. During the first several years of a claims-made relationship, claims made rates are comparatively lower than occurrence rates, and you can expect substantial annual premium increases, independent of overall rate level increases, until the claims-made relationship reaches maturity.

VERY IMPORTANT

1. All dentists in the practice must complete separate applications.
2. A copy of your practice letterhead must accompany your application.

The following are representative of facts known by me to be true. I agree that any coverage will be contingent upon the truth thereof.

Applicants

1. Answer all questions. If a question is not applicable, state N/A.
2. If space is insufficient to answer any question fully, use a separate sheet.
3. Application **MUST** be filled out, signed and dated by applicant.
4. If answer to any question is **"NONE,"** state **"NONE."**
5. An incomplete application cannot be evaluated.
6. Please type or print in ink

Limits & Terms Requested

❍ 1,000,000/1,000,000 ❍ New ❍ Renewal of Policy Number ____________________

❍ 1,000,000/3,000,000 ❍ Requested Effective Date: ________________________________

❍ Other (Please specify) __________/____________ ❍ Retroactive Date: ____

❍ Settlement - Consent Option: You have the right to consent to settlement of any claim or suit brought against you. ACE will not act to settle without your consent, subject to arbitration of the consent issue.

❍ Settlement - No Consent Option: A premium reduction is available if you agree that in the event of a claim or suit that is covered by this policy ACE has the right to contest or settle such claim or suit.

❍ Risk Management Credit Request – If, in the past three years have you taken a risk management course, you may be eligible for a premium reduction. Please attach a Certificate of Completion and an explanation of the course content.

General Information

(1) Name: ____ (2) Social Security No: _____-____ -_____

(3) Name of Practice (please provide name of legal entity): _______________________________________

(4) Do you wish a separate limit of liability to apply to this entity? ❍ Yes ❍ No
(If No, limit will be shared with applicant.)

(5) Mailing Address:____
STREET CITY COUNTY STATE ZIP

(6) Office Address: ____
STREET CITY COUNTY STATE ZIP

(7) Phone: (___) _____-_____________ (8) Date of Birth: ____________ (9) Years in Practice: _______________

(10) Address of all locations where your practice: ____

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(11) How many hours per week do you practice (include lab work, patient visitation and consultation):________________

If you practice 16 hours or less per week, please answer the following:

Please list your exact office hours (e.g., Monday 9-12): ____________________________________

When did you begin to practice part-time?____

Please give the reason you are practicing on a part-time basis: ______________________________

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Do you expect this situation to change in the future? ❍ Yes ❍ No

(12) Are you currently licensed to practice dentistry in your state(s) of practice? ❍ Yes ❍ No

List states and license numbers: ____

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(13) Narcotics (DEA) License No.: ________________________ (14) Expiration Date: ______________

(15) Do you possess another professional degree which enables you to practice in another field such as medicine?
❍ Yes ❍No If Yes, please describe:____

Do you practice in this field? ❍Yes ❍No Are you insured for this exposure? ❍ Yes ❍ No

(16) Character of Practice: (check all that apply)

❍ General Dentistry ❍ General Dentistry limited to (e.g. TMJ, Implants): ________________
❍ Dental Public Health ❍ Periodontics ❍ Endodontics ❍ Oral Pathology
❍ Pediatric Dentistry ❍ Oral Surgery ❍ Prosthodontics ❍ Orthodontics
❍ Faculty – Intramural ❍ Faculty – Non-Intramural

(17) What percentage of your practice demographics consists of:

❍ Fee for Service __________ ❍ PPO __________ ❍ Capitation _________
❍ Medicaid __________ ❍ Pro Bono ________ ❍ Other __________

(18) Under which of the following do you provide professional services?

❍ Unincorporated individual ❍ Multi-Dentist Corporation ❍ Partnership
❍ Independent Contractor ❍ Professional Association Corporation
❍ Other (describe): ____

(19) Are you an employee of, or under contract to, a government body, educational facility, or professional sports organization? ❍ Yes ❍ No If Yes, please explain and /or include a copy of contract.

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(20) Are you engaged in any written agreements and/or contracts that contains a hold harmless clause which may involve your dental practice? ❍ Yes ❍ No
If Yes, include a copy of the contract if you wish coverage considered.

(21) Give a brief description of your dental employment history, including locations and dates. ______________________

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(22) Please indicate which of the following, if any, have occurred in your practice.

A. Have you had a change in the status of your:
Dental License ❍ Yes ❍ No Hospital Privileges ❍ Yes ❍ No
Narcotics License ❍ Yes ❍ No
Please provide details of any Yes answer on a separate sheet of paper.

B. Has any governmental agency, including State Licensing Board, investigated you, suspended, revoked, or taken any other action against either your narcotics license or license to practice dentistry? ❍ Yes ❍ No
If Yes, provide a copy of the Board Transcript including resolution.

C. Have you ever been convicted of any criminal charges? ❍ Yes ❍ No If Yes, provide details from investigating agency.

D. Do you have or have you had any physical disability or injury, personal health problems including alcoholism, narcotics addiction or mental illness which affected your ability to practice dentistry? ❍ Yes ❍ No
If Yes, please explain on a separate sheet of paper.

E. Have any Medicare/Medicaid fraud charges been filed against you? ❍ Yes ❍ No
If Yes, provide details of allegations and resolution from investigating agency.

Employee/Contractor Information

(23) Complete the chart below, indicate the number of persons in each category:

	Part Time	Full Time		Part Time	Full Time
Dentists:	________	________	Dental Assistants:	________	________
MDs:	________	________	Lab Technicians:	________	________
Nurse Anesthetists:	________	________	Receptionists:	________	________
Nurses	________	________	Other:	________	________

(24) On a separate sheet of paper, please describe all independent contractors by name, position, and number of hours worked per week. Also attach a Certificate of Insurance from their Professional Liability carrier.

(25) Other than employees and independent contractors, do you share office space or staff with any other dentist?
❍ Yes ❍ No If Yes, please describe on a separate sheet of paper.

Insurance History

(26) Are you now, or have you ever practiced without Professional Liability Insurance? ❍ Yes ❍ No
If Yes, please provide dates and reason: ____

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(27) Have you had any Professional Liability Insurance refused, cancelled or non-renewed in the past 5 years?
❍ Yes ❍ No If Yes, please state reason: ____

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(28) Has any claim or suit for alleged malpractice ever been brought against you? ❍ Yes ❍ No
If Yes, please complete a Supplemental Claim Information form.

(29) Are you currently aware of any situation that could lead to a malpractice suit against you? ❍ Yes ❍ No
If Yes, please complete a Supplemental Claim Information form.

(30) To help ascertain correct coverage, it is important that the following chart be completed in detail.

	Professional Liability Insurer	Limits of Liability: Per Claim/Aggregate	Policy Period: Month/Day/Year		Type of Policy: Claims-Made or Occurrence
Current Year		/	From:	To:	
1st Prior Yr.		/	From:	To:	
2nd Prior Yr.		/	From:	To:	
3rd Prior Yr.		/	From:	To:	
4th Prior Yr.		/	From:	To:	

(31) If your expiring policy is on a claims-made basis, an Extended Reporting Period is generally available as an option of your expiring claims-made policy.

A. Are you exercising this option? ❍ Yes ❍ No

B. If No, do you want ACE to afford coverage for Prior Acts (claims for incidents which may have occurred but, as yet, no indication thereof has been made to you)? ❍ Yes ❍ No

C. Have there been any changes in your specialty, location or legal entities within the past 5 years?
❍ Yes ❍ No If Yes, Please explain: ____

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Anesthesia Information

> Please be sure to read and answer all parts very carefully.
>
> If you answer "yes" to question 33 or 34, you must complete the Anesthesia Supplement to this application.

(32) Is your practice limited to the use of local anesthesia and/or oral medication, including Nitrous Oxide euphoria?
❍ Yes ❍ No

(33) Are you treating patients who are under conscious sedation? (For purposes of this application, the use of Nitrous Oxide solely as an analgesic is not considered conscious sedation.) ❍ Yes ❍ No
If Yes, please complete the Anesthesia Supplement.

(34) Are you treating patients who are under general anesthesia (deep sedation)? ❍ Yes ❍ No
If yes, please complete the Anesthesia Supplement.

(35) Please briefly describe the use of anesthesia and the use of any type of analgesia in your practice.

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(36) Are you equipped and trained to use the following emergency procedures?

A. Positive pressure endotrachial respiratory assistance. ❍ Yes ❍ No

B. Intravenous emergency medications. ❍ Yes ❍ No

C. External cardiac massage. ❍ Yes ❍ No

Other, please specify: ____

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I hereby request that my application for professional liability claims-made coverage be submitted to ACE's Insurance Companies. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to the ACE's Insurance Companies any and all information which may relate to my insurability under the applied for professional liability claims-made coverage.

I hereby authorize ACE to release the information on this application and associated underwriting information.

I understand that my professional liability coverage will be written on a **"CLAIMS-MADE"** basis and acknowledge that this coverage will only respond to claims which arise from dental incidents taking place on or after the retroactive date of the policy and which are first made against me and reported to ACE in writing during the policy period or any applicable reporting period.

I understand the **"CLAIMS-MADE"** coverage gives me the right, subject to the terms of the policy, to purchase a Supplemental Extended Reporting Period Endorsement in the event of policy termination. Such endorsement is required to provide coverage for claims reported to ACE after the termination date, but which arise from dental incidents occurring after the Retroactive date and prior to the termination date of the policy to which this endorsement attaches.

NOTICE TO NEW YORK 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation. – New York residents only.

______________________________________ ______________________

APPLICANT'S SIGNATURE DATE