PROFESSIONALS ADVOCATE®
Insurance Company
Home Office:
225 International Circle, Box 8016
Hunt Valley, MD 21030
410-785-0050 or 1-800-492-0193

APPLICATION – CLAIMS-MADE VIRGINIA INDIVIDUAL DENTAL PROFESSIONAL LIABILITY POLICY (For Individual Professionals)

SECTION A – APPLICANT INFORMATION

Applicant Name	Date of Birth

Office Phone Number	Fax Number	Email Address

Mailing Address	Billing Address (if different from Mailing Address)
Address Line 1	Address Line 1
Address Line 2	Address Line 2
City/State/Zip	City/State/Zip

SECTION B – PROPOSED EFFECTIVE DATE

List Here: _____/_____/_____

SECTION C – RETROACTIVE DATE

List Here: _____/_____/_____

Are you requesting prior acts coverage? **If yes, please attach a copy of your current declarations page.** ☐ Yes ☐ No

SECTION D – COVERAGE LIMITS

Primary Professional Liability Limits:	$1,000,000 Per Incident / $3,000,000 Annual Aggregate	☐ Yes	☐ Other
Excess Professional Liability Limits:	Cap Limits as set forth in VA Code § 8.01-581.15	☐ Yes	☐ None
Other Professional Liability Limits:	$ _____ / $ _____	☐ Yes	☐ None
Business Liability Coverage to Match Above Limits:	☐ For All Locations ☐ Only For Location(s) # _____		☐ None

SECTION E – PROFESSIONAL OFFICE AND/OR PRACTICE LOCATIONS (NEXT 12 MONTHS)

Location #1	Address Line 1:	
	Address Line 2:	County Name:
	City/State/Zip:	# Square Feet:
	Is this location used by anyone other than you, your partners, or your employees? ☐ Yes ☐ No **If yes, please describe.**	
Location #2	Address Line 1:	
	Address Line 2:	County Name:
	City/State/Zip:	# Square Feet:
	Is this location used by anyone other than you, your partners, or your employees? ☐ Yes ☐ No **If yes, please describe.**	

SECTION F – PRACTICE HOURS AND LICENSE BY STATE (NEXT 12 MONTHS)

State	Average Hours Per Week	License Number

SECTION G – EDUCATION HISTORY (ALSO INCLUDE AN UPDATED CV)

	Start Date MM/YYYY	End Date MM/YYYY	Institution Name	State/Country
Professional School				
Internship				
Residency				
Fellowship				

SECTION H – WORK AND INSURANCE HISTORY (PAST 10 YEARS)*

OR BACK TO REQUESTED RETROACTIVE DATE IF GREATER THAN 10 YEARS

Start Date MM/YYYY	End Date MM/YYYY	State	Employer Name	Insurer Name	Policy Type and Retroactive (CM) or Inception (OC) Date	Tail Coverage
					☐ Claims-Made: _____ ☐ Occurrence: _____	☐ Yes ☐ No
					☐ Claims-Made: _____ ☐ Occurrence: _____	☐ Yes ☐ No
					☐ Claims-Made: _____ ☐ Occurrence: _____	☐ Yes ☐ No

SECTION I – ADDITIONAL PRACTICE DETAILS

1. Are you entering private practice for the first time after residency, fellowship, military service, public health, or federal employment? ☐ Yes ☐ No

2. Are you applying for part-time overage? **If yes, please complete and attach the Application Supplement – Part-Time Discount Limitation.** ☐ Yes ☐ No

3. Are you exclusively employed by a government body? **If yes, please provide details to include:** the name of this employer and indicate whether or not you are receiving separate coverage for this work. ☐ Yes ☐ No

4. Are you employed by or contracted with a nursing home, assisted living facility, or similar type of facility? **If yes, please provide details to include:** the average number of hours per week you are practicing in these facilities and whether or not you are receiving separate coverage for this work. ☐ Yes ☐ No

5. Are you practicing dentistry in correctional facilities? **If yes, please provide details to include:** the average number of hours per week you are practicing in these facilities and whether or not you are receiving separate coverage for this work. ☐ Yes ☐ No

6. Are you practicing telemedicine by diagnosing, screening, prescribing for, or treating patients without ever seeing them directly (e.g., by mail, teleconference, internet, or other electronic means)? **If yes, please provide details to include:** whether these are prospective or established patients, the state(s) these patients are located, and a description of the work you are performing. ☐ Yes ☐ No

7. Are you engaging in any business activities outside of your practice as a professional health care provider? **If yes, please provide details to include:** a description of this work and whether or not you are receiving separate coverage for this work. ☐ Yes ☐ No

SECTION J – PRACTICE SPECIALTY

☐ General Dentistry	☐ Endodontics	☐ Pedodontics	☐ Oral/Maxillofacial Surgery
☐ Dental Anesthesiology	☐ Orthodontics	☐ Periodontics	☐ Prosthodontics
☐ Oral Pathology	☐ Public Health		

1. Do you perform operative dentistry on patients under conscious intravenous or intramuscular sedation? If N_2O (nitrous oxide) is the ONLY type of conscious sedation performed, please check "No." ☐ Yes ☐ No
   If yes, please answer the following two questions.
   a. Is the operative dentistry performed in a hospital/state-licensed surgery center? ☐ Yes ☐ No
   b. Is the operative dentistry performed in your office? ☐ Yes ☐ No
2. Do you perform operative dentistry on patients rendered unconscious using anesthesia or analgesia? ☐ Yes ☐ No
   If yes, please answer the following two questions.
   a. Is the operative dentistry performed in a hospital/state-licensed surgery center? ☐ Yes ☐ No
   b. Is the operative dentistry performed in your office? ☐ Yes ☐ No
3. Do you utilize injectable neurotoxins (e.g., Botox) and/or dermal fillers (e.g., Restalyne, Juvederm, etc.) for cosmetic purposes? ☐ Yes ☐ No
4. Do you perform any plastic surgery procedures (other than injectables)? **If yes, please describe.** ☐ Yes ☐ No

SECTION K – PRACTICE AND INDIVIDUAL AFFILIATIONS

1. Will you be practicing with a dentist or a practice currently insured with Professionals Advocate? ☐ Yes ☐ No
   If yes, please complete the items below.
   Dentist or Practice Insured Name: _____
   Dentist or Practice Policy Number: _____
   Your Affiliation with the Insured: ☐ Owner ☐ Employee ☐ Contractor
2. Do you own or operate any sole proprietorship, professional corporation or association, limited liability company, hospital, nursing home, sanitarium, clinic or other outpatient facility, laboratory, or any other type business enterprise not previously listed? **If yes, please complete the items below.** ☐ Yes ☐ No
   a. Entity Name(s): _____
   b. If the entity or entities are currently insured through Professionals Advocate, should this coverage continue? ☐ Yes ☐ No
   c. If the entity or entities are NOT insured through Professionals Advocate, would you like coverage? **If yes, please submit an Organization Application for each entity.** ☐ Yes ☐ No/Separately Insured
3. Are you employing or contracting any dentist(s)? This does NOT include any dentist(s) working on behalf of a business entity that is owned by someone else. **If yes, please provide the information below.** ☐ Yes ☐ No

Dentist Name	License Number	Select Affiliation
		☐ Employee ☐ Contractor
		☐ Employee ☐ Contractor
		☐ Employee ☐ Contractor

4. Are you employing any of the following types of individuals with whom you would like to share your limits of coverage at no additional charge? This does NOT include any individuals working on behalf of a business entity that is owned by someone else. **If yes, please select all that apply below.** ☐ Yes ☐ No

☐ Dental Hygienist(s)	☐ Dental Assistant(s)	☐ Laboratory Technician(s)
☐ X-Ray Technician(s)	☐ Other – List professional(s): _____	

SECTION L – CLAIMS HISTORY (PAST 10 YEARS)

How many malpractice claims have been made or suits have been filed against you (including any claims pending and closed without indemnity payment?
List the number of claims here, or list "0" if none: _____
Please attach a Loss Run Report and any additional information.

SECTION M – GENERAL INFORMATION

1. Have you ever failed to provide complete and accurate information on any application for insurance? ☐ Yes ☐ No
   If yes, please describe.

2. Have you ever failed to give notice of an incident or claim, or failed to fully cooperate in the settlement or defense of a claim in accordance with the terms of an insurance contact? ☐ Yes ☐ No **If yes, please describe.**

3. Has any administrative or judicial proceeding ever been instituted against you or any of your employees or are you aware of any circumstances that may result in such a proceeding to examine allegations of improper conduct, competence, or utilization of professional services? ☐ Yes ☐ No **If yes, please describe and attach any additional information.**

4. Have you ever had a professional or prescription license, certification by a specialty board, or privileges at a medical institution been denied, suspended, revoked, voluntarily surrendered; or, has probation or disciplinary action ever been invoked against you? ☐ Yes ☐ No **If yes, please describe and attach any additional information.**

5. Have you ever experienced any dependency upon alcohol, narcotics, or other drugs? ☐ Yes ☐ No **If yes, please describe and attach any additional information.**

6. Are you aware of any health impairment or disability that may affect your ability to perform professionally? ☐ Yes ☐ No **If yes, please describe and attach any additional information.**

7. Have you been convicted of a felony in the past ten years? ☐ Yes ☐ No **If yes, please describe and attach any additional information.**

8. Have you ever intentionally falsified patient records, or made any addition, correction, or change to a patient record without clearly indicating it as such? ☐ Yes ☐ No **If yes, please describe and attach any additional information.**

SECTION N – CERTIFICATES OF INSURANCE (FOR HOSPITALS OR PROOF OF COVERAGE)

Facility Name and Address	Facility Name and Address

SECTION O – PREMIUM PAYMENT

The applicant will be responsible for premium payment unless an Application Supplement – Sole Agent Authorization is attached.

SECTION P – ADDITIONAL REMARKS/EXPLANATIONS/OTHER

SECTION Q – FRAUD WARNING

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.

SECTION R – APPLICANT STATEMENT

I certify (and warrant where permitted by law to do so) that the information contained in this Application and any Supplements or additional written documents are complete and true. I understand that this Application is subject to acceptance by the Company and does not bind coverage, that, where permitted by law, it will be made a part of any policy issued to me, and that any misrepresentation or omission of material facts will result in an additional premium, if warranted, or in cancellation of the policy after required notice. I hereby authorize any hospital, health care provider, medical association or society, board of medical examiners, governmental agency, insurance carrier, attorney or any other person or entity having such information to release to the Company any claims or other information which in the judgment of the Company may have a bearing on my acceptability to the Company as a liability risk. I hereby release and agree to hold harmless, any releasing party, its agents, servants and employees, as well as the Company, its directors, officers, employees or agents, from any liability arising out of the release or use of the released information notwithstanding that there may be errors or omissions in such information.

Applicant Signature	Date	Producer Signature	Date

Producer Name and Code
(to be completed by the Producer):