Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

CALIFORNIA DENTAL ENTITY APPLICATION

Mikel's
INSURANCE SERVICES
Authorized Agency

*If previously insured with Medical Protective, please provide the policy number.

Policy # _____

Please Fax or E-Mail Application: 562-928-8149 / rwalton@mikels-ins.com
If you have questions, please contact Richard Walton 1-800-928-0431

DENTAL ENTITY APPLICATION

Medical Protective
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I. ORGANIZATION INFORMATION

A. Entity Name:
(As stated in the Articles of Incorporation and all formal Entity/Clinic Names. Failure to provide complete names may void coverage.)

Entity Name _____

DBA, Fictitious Name, etc. _____

Federal Tax I.D. Number _____ National Provider Indentifier (NPI) _____

Date Entity Formed (MM/YYYY) _____

E-Mail _____ Business Fax _____ Business Phone _____

B. If the above entity does business under any other name, please list all additional entity/clinic names.

Entity Name _____

Federal Tax I.D. Number _____ National Provider Identifier (NPI) _____

Date Entity Formed (MM/YYYY) _____

C. Type of Legal Entity: (Please put an "X" in the applicable spaces.)

- ☐ Professional Corporation - sole shareholder
  - ☐ Shared Limit Coverage with my Medical Protective Individual Limits Policy **(No Employed or Contracted Dentist)**
  - ☐ Separate Entity Limits
- ☐ Professional Corporation - multiple shareholders
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Corporation (LLC)
- ☐ General Business Corporation
- ☐ Governmental (state, local or federal)
  - ☐ Not-For-Profit Clinic
  - ☐ For-Profit Clinic
- ☐ Other (Please explain) _____

D. Type of Organization: (Please put an "X" in the applicable spaces.)

- ☐ Private Practice Dental Office
- ☐ Administrative, billing and management entity
- ☐ Dental School
- ☐ Managed Care Organization/Managed Services Organization
- ☐ Non Profit Clinic
- ☐ Governmental Clinic
- ☐ Veterans Administration/Military Clinic
- ☐ Prison/Penitentiary
- ☐ Short Term Correctional Facility
- ☐ Licensed Dental Surgical Center
  - ☐ JCAHO / AAAHC Approved
- ☐ Mobile Dental Practice
- ☐ Nursing Home Based Practice
- ☐ Dental Laboratory
- ☐ Pharmacy
- ☐ Other (Please explain) _____

E. Is this entity associated with a current Medical Protective insured? ☐ Yes ☐ No
(If yes, please provide the individual, corporation or partnership policy and group number if known.)

Policy Number _____ Group Number _____

I. ORGANIZATION INFORMATION (CONTINUED)

F. Practice Location(s):
(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

2. Additional Location:

% of Practice _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

G. In which state(s) is this entity authorized to do business?

State of Incorporation _____

Certificate(s) of Authority _____

H. Preferred Billing and Correspondence Address:

☐ Location Number _____ (From Section F. above) ☐ Other (please enter below)

Number and Street _____ Suite _____

City _____ State _____ Zip Code _____

II. GENERAL INFORMATION

A. Does the entity own or share ownership in a hospital, nursing home, clinic or other health care facility? ☐ Yes ☐ No

If yes, please explain _____

B. Are you aware if any former employee(s):

1. Has ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association? ☐ Yes ☐ No

   If yes, please provide the individual name(s), explanation and date(s).

   Individual Name(s) _____ Explanation _____ (MM/YYYY) _____

2. Has ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, dental license, or Medicaid/Medicare privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

   If yes, please provide the individual name(s), explanation and date(s).

   Individual Name(s) _____ Explanation _____ (MM/YYYY) _____

II. GENERAL INFORMATION (CONTINUED)

C. Does the entity use a collection agency which has the authority to file collection suits without your knowledge? ☐ Yes ☐ No

D. Does the entity own or operate any laboratory? ☐ Yes ☐ No

If yes, is the laboratory providing services solely for your patients? ☐ Yes ☐ No

If no, please explain _____

E. Will the entity be performing activities that will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, state practice name, location and insurer name:

Practice Name _____

Location _____

Name of Insurer _____

F. Has the entity performed any contract work for or entered into any contract or agreement (written or oral) with any Entity/City/County/State/Federal Agency/Clinic including providing care at correctional facilities, prisons, mental health facilities, veterans administration, university, military, indigent care or children's clinics, etc.? ☐ Yes ☐ No

If yes, please explain _____

G. Is general anesthesia administered outside of a hospital, JCAHO or AAAHC approved facility? ☐ Yes ☐ No

If yes, please answer the following:

1. Is scheduled preventative maintenance performed on all biomedical equipment each year by a qualified biomedical technician? ☐ Yes ☐ No

   If no, please explain _____

2. Does the entity have a dental services review committee? ☐ Yes ☐ No

   If no, please explain _____

3. Does the recovery room provide full time observation by a qualified health care provider? ☐ Yes ☐ No

   If no, please explain _____

III. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit involving former or present partners, members of the corporation, and any former or present employee or independent contractor of the corporation, partnership or organization.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints, etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Is your organization or any of your employees/contractors involved now or have ever been involved in a claim or suit arising out of the rendering or failure to render professional services? ☐ Yes ☐ No

If **yes**, how many?_____

B. Is your organization or any of your employees/contractors aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes but is not limited to the following: ☐ Yes ☐ No

-Cancer -Death -Permanent Neurological Injury -Permanent Nerve Injury

If **yes**, how many?_____

C. In the last 12 months, has your organization or any of your employees/contractors received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit? ☐ Yes ☐ No

If **yes**, how many?_____

IV. ROSTER OF STAFFING INFORMATION

Please identify all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below.

	1. Last name first, then first name and middle initial (i.e. Smith, John G.)	2. Degree	3. Specialty #1-18 (Refer to Key below)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status A,B,C,D, or E (Refer to Key below)	6. Medical Protective Policy #
1.						
2.						
3.						
4.						
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16.						

Use the following key for:

Specialty: (column 3)

1. General Dentist
2. Oral and Maxillofacial Surgeon
3. Orthodontist
4. Pediatric Dentist
5. Periodontist
6. Prosthodontist
7. Endodontist
8. Dental Anesthesiologist
9. Pain Management
10. Physician
11. Dental Assistant
12. Dental Hygienist
13. Office Manager
14. Dental Lab Technician
15. Nurse Anesthetist / CRNA
16. RN / LPN
17. X-Ray Technician
18. Other (Specify job desc. in section VIII)

Individual Status: (column 5)

A. Previous Individual Medical Protective insured requesting Individual Medical Protective coverage.
B. Current Individual Medical Protective insured.
C. Requesting Individual Medical Protective coverage.
D. Applying for coverage elsewhere or covered elsewhere.
E. Shared Limit Coverage - Including Allied Health Care Professionals.
***Note: Include all applicant(s), all healthcare provider(s) and non-healthcare owner(s).**

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by the Shared Limit Additional Insured Endorsement.

****If any of the Dentists who are corporation shareholders, employees and independent contractors listed on the roster above are not currently insured with Medical Protective, please complete the Non-Insured Supplement.**

V. COVERAGE INFORMATION

A. Coverage Desired:

- ☐ Occurrence
- ☐ Claims-Made coverage without Prior Acts coverage
- ☐ Claims-Made coverage with Prior Acts coverage
- ☐ Convertible Claims-Made coverage with Prior Acts coverage

B. Requested Coverage Effective Date:

From (MM/DD/YYYY) _____ 12:01 a.m. To (MM/DD/YYYY) _____ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) _____ 12:01 a.m.
(This date is not required for Occurrence or Claims-Made without Prior Acts policies)

D. List all previous professional liability insurers in the last ten years:

1. Current Insurer _____ Current Premium _____
   ☐ Occurrence ☐ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____
2. Previous Insurer: _____
   ☐ Occurrence ☐ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____
3. Previous Insurer: _____
   ☐ Occurrence ☐ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

E. Please explain any gaps in coverage in the past ten years. _____

F. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- ☐ An extended reporting endorsement (tail coverage) has been purchased.
- ☐ An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with The Medical Protective Company, if offered, will not provide prior acts coverage.

☐ **Initial Here**

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".

G. Limits Desired: _____ Per Occurrence/Per Claim Made _____ Annual Aggregate

VI. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

Please initial the statements below.

Mandatory: All applicants must read and initial the following.

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

VII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments**") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I understand that if I cancel or terminate any coverage that may be provided by the Company, earned premium shall be computed in accordance with the standard short rate tables and procedures with a maximum penalty of up to 11%. Premium adjustments shall be made within a reasonable period of time after cancellation or termination. However, payment or tender of unearned premium shall not be a condition of cancellation.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC/PA or the Office Administrator or equivalent Authorized Representative.

Signature _____ Date Signed _____

Type or Print Name _____ Title _____

VIII. ADDITIONAL INFORMATION

Attach a separate piece of paper if additional space is needed.