Application for Claims Made Dentists Professional Liability Insurance Policy

This Application must be typed or completed in ink and signed and dated by the applicant. The information provided by you must be legible. Coverage is available to all qualified applicants as they are defined in the Article 41.020 of Chapter 41 of the Insurance Code of Puerto Rico.

Please answer every question fully and include any supporting or requested documents, and any additional information you feel may of assistance to the Underwriter such as Brochures, office letterhead, etc. Should there be insufficient spaces in the application form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.

If your application is approved by the Syndicate, the coverage can be provided with an inception or commencement date no earlier than the day SIMED receive the payment of the quoted premium. Under the claims made policy form, coverage is only provided for claims against the Insured arising out of medical incidents that occur on or after the Retroactive Date stated in the policy and which are reported in writing to the Syndicate while the policy is in effect, unless additional reporting period coverage is purchased which would provide an unlimited time period to report covered claims. During the first three policy years claims made premium are lower and they increase gradually, independent of overall rate increase, until the claims made risk reach maturity at fourth year. The premium may also be affected due to your past loss/claims experience information.

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PO Box 8969
San Juan, PR 00910

Application for Claims Made Dentists Professional Liability Insurance Policy

I. Personal Information

1. Name of Applicant: ____
   (First) (Middle) (Father Last Name) (Mother Maid Name)

2. Gender: ☐ Male ☐ Female

3. Mailing Address: ____

   ____

4. Work or Professional Office Address: ______________________________
   No. Street

   ____
   City State Zip Code

5. Home Address: ____
   No. Street

   ____
   City State Zip Code

6. Office Telephone Number: _______________ Fax Number: ________________
   Work Telephone Number: _______________
   Home Telephone Number: ________________ E-Mail Address: _____________
   Mobile Phone Number: ___________________Website Address: ____________

7. Date of Birth: ______ ______ ______ Place of Birth ______________________
   Mo. Day Yr.

8. Social Security No: ______________________

9. Dental School attended: _______________, _________, _______, ____________,
   Name Degree City State/Country

   ______________, _______________, ______________,
   From To Year Graduated

10. Other Training

    Name of School/Institution ________________

    City/State/Country______________________

    Type of Training and Degree ________________

    From ____________ To ________________

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11. Are you Board Certified? ☐ Yes ☐ No

If yes, indicate each Specialty Board and provide copy of the certification issued by the Board.

____

12. Are you duly registered and licensed to practice your profession in the Commonwealth of Puerto Rico? ☐ Yes ☐ No

License No: ________
Register No. ________ Date Issued________ Expiration Date _________

Provide a certification issued to SIMED by the corresponding Licensing Dental Board indicating that your license is in force and have never been suspended or revoked. Attach a copy of your license and your registration card.

13. Please indicate your Federal DEA License No. _____________

II. Practice/Rating Information

1. Please specify the type of coverage you are applying for:

a. Primary Policy Limits
- ☐ $100,000 per medical incident/$300,000 aggregate

b. Excess over primary policy limits
- ☐ $150,000 per medical incident/$300,000 aggregate
- ☐ $400,000 per medical incident/$800,000 aggregate
- ☐ $650,000 per medical incident/$1,300,000 aggregate
- ☐ $900,000 per medical incident/$2,700,000 aggregate

2. What is the nature of your current practice?

- ☐ Solo Practitioner
- ☐ Solo or Single Professional Corporation **(PC) (If yes, please complete the attached Exhibit 1)**
- ☐ Multi Professional Corporation (PC) **(If yes, please complete the attached Exhibit 1)**
- ☐ Independent Contractor
- ☐ Professional Association (P.A.) **(Provide details on the attached sheet for this purpose)**
- ☐ Professional Partnership **(If yes, please complete the attached Exhibit 1)**
- ☐ Other Describe or provide details on the attached sheet for this purpose)

3. Indicate percentage of your time involved in the following areas of practice (percentages must total 100%)

- ☐ General Dentistry ______%
- ☐ Pediatric Dentistry ______%
- ☐ Endodontic ______%
- ☐ Orthodontics ______%
- ☐ Prosthodontics ______%
- ☐ Periodontics ______%
- ☐ Oral or Maxillofacial Surgery ______%
- ☐ Other (describe below) ______%

____

SIMED

4. Do you have employees? ☐ Yes ☐ No

If yes, please complete the attached Exhibit 1.

*General Anesthesia: is controlled state of unconsciousness accompanied by a partial or complete loss of protective reflexes, including the inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or no pharmacologic method, or combination thereof.

**Conscious Sedation is a depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command, produced by a pharmacologic or no pharmacologic method or combination thereof.

5. Do you or any of your employees render patient's unconscious or perform operative dentistry on patients rendered unconscious on or off your premises, through the administering of any *general anesthesia or analgesia?

☐ Yes ☐ No

If yes, please indicate where the procedures are performed: ☐ in office ☐ in hospital

6. Do you or any or your employees administer **conscious sedation?

☐ Yes ☐ No

If yes, indicate the type of conscious sedation:

a. Intramuscular _____%
b. Intravenous ______%
c. Nitrous oxide ____%
d. Combination of above ____%

Please, provide a copy of the authorization to manage sedation and general anesthesia.

III. Additional Practice Specialty Information

a. Do you extract impacted teeth? ☐ Yes ☐ No

b. Do you do full mouth rehabilitation solely for cosmetic purposes? ☐ Yes ☐ No

c. Do you place implants? ☐ Yes ☐ No

If yes, please indicate the all the information pertaining the special training you have received on it (school, hours, etc.)

____

d. Do you assist oral surgeons in surgery? ☐ Yes ☐ No

____

____

If any answer for the above is yes, please explain. (If additional space is required, please provide information on business the attached Sheet for Additional Details making reference to this question)

e. Do you perform any additional dental technique or procedure? ☐ Yes ☐ No

If yes, please describe it and explain the formal training you have received on it.

____

7. List hospitals and/or clinics, at which you are applying for staff privileges or have been granted privileges as member of their Medical Faculty?

☐ Yes ☐ No

a: Name____

Mailing Address____

b: Name____

Mailing Address____

c: Name____

Mailing Address ____

If there are more, please list on the attached sheet for Additional Details.

8. Please list in the attached **Exhibit 3** all institutions (hospital or clinics) you would like SIMED to send certificate of insurance if a policy is issued.

IV. Claims/Rating Information

The applicant must provide a loss run or loss experience report with all previous insurers. The report must be attached to this application for insurance.

1. Has any claim or suit for any alleged malpractice ever been brought against you?

☐ Yes ☐ No

If yes, answer the following and complete the attach Exhibit 2.

a. How many claims pending? _______
b. How many claims close without payment? ______
c. How many claims close with payment? _______

V. Coverage Information

1. On what date do you wish the coverage insurance to be effective (inception date)?

______ _______ ________
Mo Day Yr
12:01 a.m. Standard Time

2. Have you ever practiced without insurance? ☐ Yes ☐ No

If yes, please explain____

____

3. Please provide the following information pertaining to your past years of professional liability insurance carrier:

FROM	TO	Retroactive Date	Previous Insurance Carrier	Policy Limits	Premium

4. Do you have an excess or umbrella professional liability or a primary policy in force policy with other insurance company?

☐ Yes ☐ No

If it is affirmative, please provide Insurer's name: __________________,

Policy period: __________ (From (Mo/Day/Yr)) ___________ (To (Mo/Day/Yr)), Policy No., __________ Retroactive Date ________________and Limits of liability______________________ and Policy Form No. _______________.

5. Have you ever had a professional liability insurance that has been declined, cancelled, issued on special terms, or not renewed? ☐ Yes ☐ No
If yes, give full details:
____
____

VI. Other Underwriting Information

		Yes	No
1.	Are you in active United States military service?	☐	☐
2.	Are you employed full time by the Federal Government (but not in active United States military service)?	☐	☐

3. Are you enjoying any kind of statutory immunity or of any cap in your professional liability in any health facility in which you provide professional services?
If yes, indicate the name and location of the facility and explain.

Name of health facility ____________________; Location ____________________

4. Do you own or operate any hospital, sanitarium or clinic with bed and board facilities, laboratory, or other business enterprise? ☐ ☐

(Please note that if a policy is issued by us you will not be covered for your liability as a proprietor, superintendent, partner, hospital administrator, officer, stockholder, or member of the board of directors, trustees or governors of any hospital, sanitarium, clinic with bed and board facilities, nursing home laboratory, or other business enterprise)

Name of the health facility____

5. Do you teach in or are you associated with a dental school? ☐ ☐
If yes, indicate name of school: ____________________________________

6. Will you be performing activities which will be covered by another professional liability policy?
If yes, are you an: ☐ Employee ☐ Independent Contractors ☐ Resident/Fellow ☐ Faculty Location________________ Name of Insurer______________________

7. Do you have contract as a provider of the Puerto Rico Government Health Plan? ☐ ☐

Yes No

8. Have you signed or will you sign any contract or agreement to assume the liability of others? ☐ ☐
(Please be aware that if a policy is issued by us you will NOT be covered under this policy for the liability of others which you have assumed under a contract or agreement.)

9. Has your professional license to practice medicine or license to prescribe or dispense narcotics refused, ever been suspended, revoked or restricted, renewal refused or accepted on special terms, or have you ever voluntarily surrounded the same? ☐ ☐

10. Have you ever been placed on probation by any licensing board? ☐ ☐

11. Has any hospital ever denied restricted, suspended or revoked your privileges or placed you on probation? ☐ ☐

12. Have you ever been convicted of a criminal offense other than a motor vehicle violation?

13. Has your membership in any professional society ever been refused, suspended or revoked? ☐ ☐

14. Have you ever had board certification refused or revoked? ☐ ☐

15. Have you had a problem with or been treated for alcoholism, narcotic addiction or mental illness? ☐ ☐

16. Have you now or have you ever had a chronic illness or physical defect that impairs or could impair your ability to practice your specialty? ☐ ☐

If answer to any of the above questions is yes, please give full details on the attached sheet for additional details referring to the question involved.

IMPORTANT: To consider this application the below certification and release must be signed by the applicant.

CERTIFICATION AND RELEASE

The applicant:

1. **Understand and accepts that this application does not bind the applicant or the Syndicate to complete the insurance, but it is agreed that this form shall be the base of the contract should a policy(ies) be issued, and it will be attached to and made part of this policy(ies). The applicant agrees that if the information supplied on this application changes between the date of this application and the time when the policy(ies) is issued, the applicant we will immediately notify the Syndicate of such change.**

2. **I Understand and accept that signing this application and tendering premium does not bind or obligate the Syndicate to grant the limits of liability of the policy(ies) as requested. If the**

Syndicate determines that the applicant is eligible for the limits, the corresponding quote indicating the premium will be provided

3. **Understands and accepts that the policy applied for provides coverage on a claims made basis for only those claims that are made against the insured while the policy(ies) is in force, but arising out of a medical incident occurring on or after the retroactive date to be stated in the Declarations Page of the policy(ies), if issued.**

4. **Understands and accepts that coverage ceases with the termination of the policy or policies unless options available are exercised according to its terms.**

5. **Certifies that he or she is duly registered and certified by the corresponding Puerto Rico Dental Board for the professional specialty and/or specialties he or she engages in, as indicated in this application and, therefore, understands and accepts that the coverage provided by the policy(ies) applied for is exclusively limited to his or her professional practice pertaining only to the registered specialty to which he/she has been authorized and certified.**

6. **Grants permission to the Syndicate to request information regarding his or her professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which he or she currently has been granted privileges and/or formerly has had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.**

   The information requested may include otherwise privileged or confidential material relative to his or her professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. The applicant releases and agrees to hold harmless the Syndicate and its representatives, employees and agents which may result from the gathering or legal use of such information to evaluate the issuance of the requested policy(ies).

7. **Hereby authorizes the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which he or she currently has or formerly has had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities and present and past employers to submit information requested by the Syndicate including otherwise privileged or confidential material relative to his or her professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. The applicant hereby further releases and agrees to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information.**

8. **Grants permission to the Syndicate to disclose to any institutions as to which I have admitting privileges or other medical relationship, any matter involving a pending or closed claim, cancellation or non-renewal of medical malpractice insurance, or any other matter which could reasonably be expected to affect the interest of such institutions as to any insurance which the Company may provide, and to disclose any information which the Company may be required to disclose by law or regulation.**

9. **Understands that any person who knowingly renders a false report, makes a misrepresentation**

of facts or includes in any application for insurance any matter which such person knows is untrue, commits a fraudulent act and is in violation of section 12.190 of the Insurance Code of Puerto Rico and certifies that the foregoing answers and statements are complete, true and correct to the best of his or her knowledge and belief.

AVISO IMPORTANTE

El Artículo 27.320 del Código de Seguros de P.R. dispone lo siguiente:

"Cualquier persona que a sabiendas y que con la intención de defraudar presente información falsa en una solicitud de seguro o, que presentare, ayudare o hiciere presentar una reclamación fraudulenta para el pago de una pérdida u otro beneficio, o presentare más de una reclamación por un mismo daño pérdida, incurrirá en delito grave y convicto que fuere, será sancionado, por cada violación con pena de multa no menor de cinco mil (5,000) dólares, ni mayor de diez mil (10,000) dólares o pena de reclusión por un término fijo de tres (3) años, o ambas penas. De mediar circunstancias agravantes, la pena fija establecida podrá ser aumentada hasta un máximo de cinco (5) años; de mediar circunstancias atenuantes, podrá ser reducida hasta un mínimo de dos (2)".

IMPORTANT WARNING

Article 27.320 of the Insurance Code of P.R. arranges the following:

"Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, or will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with pain of no smaller fine of five thousand (5,000) dollars, nor greater of ten thousand (10,000) dollars or imprisonment by a fixed term of three (3) years, or both pains. To mediate aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2)".

___________________________________ ______________________

Applicant's Signature **Date**

Authorized Representative
or Broker Name: ________________________ **Telephone Number:**__________________

Mobile Phone Number:________________________ **Fax Number:**_______________________

Website Address: ____

Mail Address: ____

Exhibit 1

Partnership/Corporations (The professional Liability Coverage Partnership/Corporation won't be provided unless specifically approved by the Syndicate. Review of this application creates no obligation upon the Syndicate to issue a policy to provide the Partnership/Corp. Liability Coverage.

1. ☐ Single Professional Corp. ☐ Multi-Professional ☐ Partnership

   ☐ Insured by SIMED ☐ Insured by other company

   Give the name and address of the professional partnership or corporation.

   ____

   If it is a partnership, include copy of partnership agreement that states the share in the profit and losses of each partner. If it is a corporation, include copy of the certificate and articles of incorporation to this application for insurance. If it's insured by other company, provide the name of the professional liability insurance carrier and the policy number.

   ____

2. Does your partnership or corporation provide services to any health facility: if yes, please indicate name(s).

   ____

3. List all partners, members or stockholders that participate with you in a professional partnership or corporation, their specialties, professional licenses, insurance carrier and policy number.

Name	Specialty	Professional Puerto Rico License Number	Insurance Carrier Policy Number
________________	____________	________________	______________
________________	____________	________________	______________
________________	____________	________________	______________

4. Do you or does your partnership or corporation employ any of the following?
   Provide copy of the contract and licenses for each one of your employees, or employees of the partnership or corporation.

____________________	____________________	__________
Name of Applicant	Signature	Date

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		Number of Employees	No. of Indep. Contractors
a.	Oral or Maxillofacial Surgeons	_________	___________
b.	Dentists Using General Anesthesia	_________	___________
c.	Dentist Using IVM Sedation	_________	___________
d.	Dentist-All Others	_________	___________
e.	Dental Assistants	_________	___________
f.	Nurse Anesthetists	_________	___________
g.	Dental Hygienists	_________	___________
h.	Technicians - X-ray	_________	___________
i.	Other (describe)	_________	___________

____
____

5. If you, your medical partnership or medical corporation employs any health care Professionals listed above, please indicate the individual's name, specialty and insurance carrier below:

Name	Professional License No.	Specialty	Insurance Carrier
_______________	________________	______________	_________________
_______________	________________	______________	_________________
_______________	________________	______________	_________________
_______________	________________	______________	_________________

Provide copy of the contract and licenses for each employed health care professional.

______________________	________________________	___________
Name of Applicant	Signature	Date

Exhibit 2
Claims Information

Please supply the following information regarding any claims or suit against you weather dismissed, settled out of court, judgment or pending. This form should be photocopied and filled out separately for each claim.

1. Name of Patient ___________________________________
2. Allegation ____

   ____

   ____

   ____

   ____
3. Date of incident leading to allegation ___________________
4. Claim No. and or Civil Case No. ____________, _____________
5. Date claim was made or filed ___________________
6. Insurance Company defending you _______________
7. Indicate the status or disposition of the Claim or Complaint:

   Pending ☐ (Provide copy of the extrajudicial claim or the suit and summons)

   a. Insurer's loss reserve _____________ Loss adj. expense reserve _______________

   Closed ☐

   a. Exact date closed ____________
   b. Total settlement or judgment _______________
   c. Amount paid on your behalf ________________

____________________	_____________________	__________
Name of Applicant	Signature	Date

Form No. SMA-71-13 Rev. 2016 (Dentist)

Exhibit 3

List hospital or clinics you would like SIMED sent certificate of insurance:

1. Name____ Telephone___________

   Mailing Address____

   E-mail____

   Contact Name____________________________________

2. Name____ Telephone___________

   Mailing Address____

   E-mail____

   Contact Name____________________________________

3. Name____ Telephone___________

   Mailing Address____

   E-mail____

   Contact Name____________________________________

4. Name____ Telephone__________

   Mailing Address____

   E-mail____

   Contact Name____________________________________

5. Name____ Telephone___________

   Mailing Address____

   E-mail____

   Contact Name____________________________________

______________________	______________________	___________
Name of Applicant	Signature	Date

SIMED

Sheet for Additional Details

Name of Applicant | Signature | Date