623 SW 10th Avenue
Topeka, KS 66612
800-232-2259
www.kammco.com

Dentist Application for Claims-Made Professional Liability Insurance
New Business

Application Instructions & Required Information

- Answer all questions completely and accurately.
- Complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, use the **Comments** section at the end of this application or attach separate documentation.
- Sign and date the application where indicated.
- Provide claim information for the last five years and include current company loss runs.

Requested Effective Date (MM/DD/YYYY): _____

A. Applicant Information

Agency Name (if applicable): _____

Applicant's Name (First, Middle, Last): _____

Date of Birth (MM/DD/YYYY): _____ **Social Security Number:** _____

Designation: ☐ Dentist ☐ Other (specify below)
Specify Other: _____

Gender: ☐ Male ☐ Female

Applicant's Business Information

Street: _____ City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Fax: _____ Email: _____

Applicant's Home Information (P.O. Box not accepted)

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Applicant's Billing/Mailing Information ☐ Home ☐ Business ☐ Other (specify): _____

Street: _____ City: _____ State: _____ Zip: _____

Name of Business Manager / Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other

B. Current Coverage

1. Existing Form of Insurance: ☐ Occurrence ☐ Claims-Made

If Claims-Made, what is your retroactive date? (MM/DD/YYYY): _____

2. List your insurance coverage for the past five years:

Carrier Name	Policy #	Coverage Dates	Limits	Retroactive Date

C. Requested Coverage

1. Limits of Liability (Limits are expressed as per claim and annual aggregate)

Select One: ☐ $500,000 / $1,500,000 ☐ $1,000,000 / $3,000,000

D. Practice Information

1. If you are employed, indicate the name of your employer: _____

2. If you are an independent contractor, name each entity with which you have contracted dental services:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

3. List each professional corporation, association, partnership, or other healthcare-related entity in which you have an ownership.

(Complete one Corporate Healthcare Application for each organization listed below, if coverage is desired.)

Name	Description of Interest	% of Practice

4. If you, as an individual, employ or contract with other medical professionals, complete the following:

Type	Number	Employment	Current Insurer
Licensed Dentists, Oral Surgeons or MDs		☐ Employee ☐ Contractor	
Dental Hygienist		☐ Employee ☐ Contractor	
Technicians		☐ Employee ☐ Contractor	
Nurses (including CRNAs)		☐ Employee ☐ Contractor	

E. Education, Training, and Work Experience

1. Provide the following information about your school of graduation.

Name of School: _____

City & State of School: _____

Year of Graduation: _____

2. How many years have you been practicing Dentistry: _____

3. List your professional degree(s): _____

4. Are you certified by an approved specialty board? ☐ Yes ☐ No

If yes, certifying board name(s): _____

Date(s) of initial certification: _____

Date(s) of recertification: _____

5. If you are not certified, are you board eligible? ☐ Yes ☐ No

If yes, date eligibility expires: _____

6. List each state where you are licensed to practice as well as your license number.

State	License Number

7. List all the places where you have practiced your profession during the past five years.

Facility / Practice Name	City	State	Dates (MM/YY to MM/YY)
			_____ to _____
			_____ to _____
			_____ to _____
			_____ to _____

8. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No

If yes, describe the changes below.

F. Classification

1. Provide information about the character of your practice. Check all that apply and indicate what percentage of your practice they compose.

_____ % ☐ General Dentistry		_____ % ☐ General Dentistry Limited (e.g. TMJ, Implants)	
_____ % ☐ Dental Public Health		_____ % ☐ Oral Surgery	
_____ % ☐ Pediatric Dentistry		_____ % ☐ Endodontics	
_____ % ☐ Faculty – Intramural		_____ % ☐ Prosthodontics	
_____ % ☐ Faculty – Non-Intramural		_____ % ☐ Oral Pathology	
_____ % ☐ Periodontics		_____ % ☐ Orthodontics	

Questions 2–5 pertain to your use of anesthesia and analgesia.
Make certain you read and answer all questions carefully.

If you answer **"yes"** to question 2, 3, 4 or 5 you must completed the **Anesthesia / Analgesia Questionnaire** attached to this application.

2. Do you limit your practice to local anesthesia and/or oral medication? ☐ Yes ☐ No

3. Is nitrous oxide used when treating patients? ☐ Yes ☐ No

4. Are you treating patients who are under conscious sedation?
(Note: For purposes of this insurance application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.) ☐ Yes ☐ No

5. Are you treating patients who are under general anesthesia (deep sedation)? ☐ Yes ☐ No

G. Underwriting Questions

Explain any **"yes"** answers to any of the questions in this section in the **Comments** section at the end of this application.

1. Has your license to practice dentistry ever been denied, revoked, suspended, voluntarily surrendered, or subject to investigation or probationary terms in any jurisdiction? ☐ Yes ☐ No

2. Has your license to prescribe or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered, or subject to investigation or probationary terms? ☐ Yes ☐ No

3. Has your membership in any dental society, specialty board, or professional organization ever been denied, suspended, revoked, voluntarily surrendered, or subject to investigation or probationary terms? ☐ Yes ☐ No

4. Have you ever been, or are you currently, the subject of investigation, disciplinary proceedings, or reprimand by any administrative agency, licensing entity, dental society, hospital, or professional organization? ☐ Yes ☐ No

5. **Has any application for hospital staff privileges ever been denied or granted with restrictions or conditions?** ☐ Yes ☐ No

6. **Have your hospital privileges ever been modified, revoked, or non-renewed?** ☐ Yes ☐ No

7. **Have you been subject to probation or disciplinary action related to your hospital privileges?** ☐ Yes ☐ No

8. **Have you ever had board certification refused or revoked?** ☐ Yes ☐ No

9. **Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?** ☐ Yes ☐ No

10. **Has your professional liability insurance ever been declined, canceled, refused, non-renewed, or issued on special terms?** ☐ Yes ☐ No

11. **Has any administrative agency, licensing entity, hospital, or professional organization ever requested you be examined or evaluated by a physician because of an alleged mental condition, alcohol abuse, or drug dependency?** ☐ Yes ☐ No

12. **Have you ever had an illness or physical disability that impairs or could tend to impair your ability to practice dentistry or could put your patients at risk?** (e.g. alcoholism, convulsive disorders, Hepatitis B, HIV positive, mental illness, multiple sclerosis, narcotics addition, rheumatoid arthritis, etc.) ☐ Yes ☐ No

    If you answered yes:

    a) State your illness or disability in the **Comments** section at the end of this application.

    b) Include a statement from your physician that attests to your fitness to practice and includes the complete details of your illness or disability.

13. **Have you ever been treated for alcohol or drug addiction or mental illness?** ☐ Yes ☐ No

H. Claim Information

Explain any **"yes"** answers to any of the questions in this section in the **Comments section** at the end of this application.

1. **Have any claims or lawsuits ever been made against you, the owners of your practice/facility, or your employees or contractors that arose out of the performance of professional services rendered – or which should have been rendered – by any person for whose acts or omissions you are legally responsible?** ☐ Yes ☐ No

    If yes, indicate the number of previous and/or pending claims or lawsuits: _____

    Please complete the **Claim Information Worksheet** (attached to this application) for each claim or lawsuit indicated above. Make additional copies as needed.

I. Comments

Add comments in the space below. Include the Section and Question Number you're referencing.
If you need additional space, attach additional documentation to this application.

Disclosure Statement and Authorization for the Release of Information

Execution of this application by the applicant does not bind KAMMCO to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

If a policy is issued, the policy will be issued on a claims-made basis and will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy.

The applicant represents the statements and answers made herein are true, and makes the same for the purpose of inducing KAMMCO to issue the policy for which application is hereby made. It is understood that this entire policy shall be void if, whether before or after a loss or claim, the applicant has intentionally concealed or misrepresented any material fact or circumstance concerning the insurance or subject thereof.

I hereby authorize KAMMCO to release the information on this application and associated underwriting information to any insurability committee(s) established by the American Dental Association and/or my state dental society. I consent to the review of any incident or occurrences likely to

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

_____

Signature of Applicant

_____

Date (MM/DD/YYYY)

Please return this application, along with any necessary attachments,
by email to underwriting@kammco.com or by fax to **785.232.4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.

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Anesthesia Addendum

Complete this form **ONLY** if you have answered **"Yes"** to questions 2, 3, 4, or 5 in Section F of the **Dental Professional Liability Application**. Return this form as an attachment to the **Dental Professional Liability Application**.

In this questionnaire, "anesthesia" means any form of inhalation, intravenous or other intramuscular anesthesia or analgesia and/or any combination thereof. The following definitions of **conscious sedation** and **general anesthesia** are provided:

CONSCIOUS SEDATION – is a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof. For purposes of this insurance application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

GENERAL ANESTHESIA (to include deep sedation) – is a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

A. Specify the type of anesthesia/analgesia used when treating patients under conscious sedation.
(When used in combination with other anesthetic or analgesic agents)

1. Inhalation: _____ Nitrous Oxide (when used in combination with other anesthetic or analgesic agents): _____ Other: _____
2. Intravenous: _____
3. Intramuscular (including submucosal): _____
4. Combination: _____
5. Where are conscious sedation procedures performed?

☐ Office Only ☐ Hospital Only ☐ Both Office & Hospital

B. Specify the type of anesthesia/analgesia used when treating patients under general anesthesia.
(When used in combination with other anesthetic or analgesic agents)

1. Inhalation: _____ Nitrous Oxide (when used in combination with other anesthetic or analgesic agents): _____ Other: _____
2. Intravenous: _____
3. Intramuscular (including submucosal): _____
4. Combination: _____
5. Where are conscious sedation procedures performed?

☐ Office Only ☐ Hospital Only ☐ Both Office & Hospital

C. How many years have you used conscious sedation or general anesthesia in your office? _____

D. In your office, how many times per week (on average) do you use conscious sedation or general anesthesia? _____

E. Please specify the type of major and minor surgical procedures performed while treating patients under conscious sedation or general anesthesia.

Major Surgical Procedures:

Minor Surgical Procedures:

F. Please indicate if you have had the following training and if so, the date and period of time spent in training:

1. Hospital training in the use of general anesthesia? _____
2. University training in the use of general anesthesia? _____
3. Hospital training in the use of general sedation? _____
4. University training in the use of conscious sedation? _____
5. Other types of training (i.e., Continuing Education programs):

G. I am certified by, or am a member of, the following organizations that require training in general anesthesia:

☐ AAOMS ☐ ABOS ☐ Fellow, ADSA ☐ Member, ADSA

☐ Other (specify): _____

H. I am equipped and trained to use the following emergency procedures:

☐ Positive Pressure Endotracheal Respiratory Assistance

☐ Intravenous Emergency Medications

☐ External Cardiac Massage

☐ Other (specify): _____

I. What type of emergency equipment do you have in your office?

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Claim Information Worksheet (Please make additional copies if necessary)

No Claims: ☐ ***A signature is required regardless of claim history.***

Patient's Name: _____ **Patient's Gender:** ☐ Male ☐ Female
(Last, First, Middle)

Allegation:

Date of Incident: _____ **Date Reported:** _____

Insurance Carrier: _____

Was a lawsuit filed?: ☐ Yes ☐ No Are/were you the primary defendant?**:** ☐ Yes ☐ No

If "No," please describe your involvement in the patient care:

Additional Defendants: _____

Location of Occurrence: _____

Claims Status:

☐ Open ☐ Closed ☐ Date Closed: _____

If open, indicate reserve amount: **$** _____ (*Reserve Amount Required)*

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment

b. Amount of settlement or judgment: **$** _____

I understand information submitted herein becomes part of my **Professional Liability Insurance Application** as submitted.

_____ _____
Signature Date

Please return application by email to **underwriting@kammco.com** or by fax to **785.232.4704**.
If you work with a KAMMCO guest agent, please submit directly to your agent.