Robert Ellis & Associates
Insurance Services

Please return this completed form to
ROBERT ELLIS & ASSOCIATES, P.O. BOX 2140
MANDEVILLE, LA 70470
OR FAX IT TO (985) 674-3881
Attention: Dentist's Professional Liability

FORTRESS

FORTRESS ORGANIZATION APPLICATION

Answers must be typed or printed in ink. Please answer all questions completely. You must sign and date the application. Signature stamps or the signatures of office personnel are not acceptable. Groups of 25 or more dentists must complete the Organization Structure Form, which is attached. If additional space is needed, please use a separate sheet of paper.

1. Organization Name: ______________________
2. Effective Date: ____________ 3. Retroactive Date: ____________
4. Mailing Address: ______________________
   Address Line 2: ______________________
   City: ____________ State: ________ Zip Code: ________
   Phone Number: (____)__________ Fax Number: (____)__________
   Email Address: ______________________
5. Does the organization have a website? ☐ Yes ☐ No
   Website Address: ______________________
6. Does the Organization advertise? ☐ Yes ☐ No If yes, please provide a copy of the advertisement(s).
7. Name of President/Partner: ______________________
8. Name of Business Manager: ______________________
9. The organization applying for coverage is one of the following legal entities:
   ☐ Sole Shareholder Organization (Submit a copy of article of Incorporation)
   ☐ Limited Liability Company (Submit a copy of Articles of Incorporation)
   ☐ Partnership (Submit a copy of the partnership agreement)
   ☐ Multi-Shareholder Corporation (Submit a copy of Articles of Incorporation)
   ☐ Other (Describe) ______________________
10. Federal Tax ID Number: ______________________
11. Does the corporation operate under any other names (Doing Business As, "DBA's")? ☐ Yes ☐ No
    If yes, please list all:
    1. ______________________
    2. ______________________
    3. ______________________
    4. ______________________

Agent: ______________________ Agent License Number: ______________________

12. Previous insurance carriers-last ten years (List most recent first)

Carrier Name	Policy Period	Limits	Claims Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Note: It is necessary that you provide a current written statement regarding loss history from each carrier listed above for the last ten years. Please provide a copy of the Declarations page for the most recent carrier.

13. Limits of Liability **(Skip this section if the organization is in a state with a Patient Compensation Fund)**

Note: The offering of the following policy limits and type of coverage by Fortress Insurance Company should not be deemed to express or imply that any particular policy limit or type of coverage is not adequate for an insured. It is the sole responsibility of each insured to select an appropriate policy type and limits of coverage.

TYPE OF COVERAGE

☐ Claims-made

☐ Occurrence

LIMITS OF COVERAGE

☐ $100,000 per patient/$300,000 annual total limit

☐ $200,000 per patient/$600,000 annual total limit

☐ $250,000 per patient/$750,000 annual total limit

☐ $500,000 per patient/$1,000,000 annual total limit

☐ $1,000,000 per patient/$3,000,000 annual total limit

☐ $2,000,000 per patient/$6,000,000 annual total limit (Company Approval Required)

14. Profile Questions. Include details to each question in the space provided. Attach additional, if necessary.

	YES	NO	
A.	☐	☐	Has the organization's professional liability insurance ever been canceled for non-payment of premium? If yes, indicate date(s) and reasons for such cancellation(s): ____________________ **This question does not apply to applicants in Missouri.**
B.	☐	☐	Has the organization ever filed for bankruptcy?
C.	☐	☐	Has the organization's professional liability insurance ever been declined, canceled, non-renewed or issued on special terms? (Including but not limited to restrictive endorsements, surcharged premium, etc.) **This question does not apply to applicants in Missouri.**
D.	☐	☐	Does/Has the organization owned and operated, participated in or directed any entrepreneurial business? If yes, indicate name(s), address(es), and type(s) of business(es): ____________________

E.	☐	☐	Does the organization, through its employed dentists, treat or intend to treat any patient by means of unconventional therapeutics, which may be considered human experimentation, or conceivably be subject to regulatory approval? If yes, identify dentist(s) in the corporation who participate in this activity on a separate sheet of paper.
F.	☐	☐	Does the organization contract to any governmental facility? If yes, please provide a copy of any contract you have executed.

15. Please provide information on all claims/suits reported within the last ten years, including the following:

A.
- Complete narrative of each claim (Use Supplement Incident/Claim Form included in application).
- Reserves on pending claims (both indemnity and expense).
- Payments on any closed claim/suit (both indemnity and expense)

B. Please provide total premium paid, by year, for the last ten years.

1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$

ORGANIZATION CENSUS

16. Please provide census information on dentists who are partners, shareholders, officers, directors, employees or independent contractors. Attach additional sheet, if necessary.

Codes: 01-Partner 02-Shareholder 03-Officer 04-Director 05-Employee 06-Independent Contractor

Name/Code	Specialty	Is this the Dentist's primary practice location? (Yes or No)
1.		
2.		
3.		
4.		
5.		

6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
24.		
25.		

17. Allied Health Personnel ☐ Yes ☐ No

Note: Coverage is limited to the scope of employment. Limits of liability are offered on a shared basis.

A. Dental Assistants Total Number ________________

B. Dental Hygienists Total Number ________________

C. Other Total Number ________________

List Names and identify by line letter (A, B, or C).

18. Practice Information

List all current practice locations in this section. Include all locations whether or not Fortress Insurance is desired at that location. If additional space is required to show more than three practice locations, use a separate sheet of paper. Please include facility code(s) to identify all that are applicable.
(Facility Codes (Please Indicate all that Apply).

01-Government Location
02-HMO, IPA, PPO
03-Hospital
04-Dentist Office
05- Surgicenter
06- Commercial Laboratory
07- Industrial Clinic
08- Dental Management Services Organization
09- Other

A. Facility Code: ____________________

Address: ____________________

Address Line 2: ____________________

City: ____________ State: ________ Zip Code: ________

Country: ____________ Telephone Number: (____)________

Name of Business Manager:
(If other than listed in question 8). ____________________

Is this your primary office location? ☐ Yes ☐ No

B. Facility Code: ____________________

Address: ____________________

Address Line 2: ____________________

City: ____________ State: ________ Zip Code: ________

Country: ____________ Telephone Number: (____)________

Name of Business Manager:
(If other than listed in question 8). ____________________

Is this your primary office location? ☐ Yes ☐ No

C. Facility Code: ____________________

Address: ____________________

Address Line 2: ____________________

City: ____________ State: ________ Zip Code: ________

Country: ____________ Telephone Number: (____)________

Name of Business Manager:
(If other than listed in question 8). ____________________

Is this your primary office location? ☐ Yes ☐ No

ORGANIZATION STRUCTURE FORM
(FOR GROUPS OF 25 OR MORE)

Describe the Organization's...

A. Referral policy: ______________________________

____

B. Compensation policy, including incentives: ______________________________

____

C. Quality control procedures: ______________________________

____

D. Employment qualifications for employed dentists or dentist specialist: ______________________________

____

E. Risk management procedures, include how incidents or patient complaints are handled: ______________________________

____

F. Anesthesia/sedation procedures, include emergency procedures: ______________________________

____

G. Medical History and Informed Consent Forms: ______________________________

____

H. Collection and write-off procedures, include the amount written-off for each of the last 3 years: ______________________________

____

____

I. Business or market segments that represent greater than 10% of the organizations annual revenues (i.e., Medicare, Medicaid): ______________________________

____

Provide the following:

J. Latest audited financial statement: ______________________________

____

K. Total revenues for the last 3 years: ______________________________

____

L. Total number of employed dentists for each of the last 3 years: ______________________________

____

HIPAA STATEMENT

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy and Security Regulations, the organization is a "covered entity" and we are a "business associate" of the organization. In performance of services under this policy, we sometimes must use and/or disclose individual identifiable health information ("Protected Health Information including Electronic Protected Health Information") that is maintained in any form or medium by the organization. We agree to abide by the obligations set forth in the HIPAA Privacy and Security Regulations and only use and/or disclose the Protected Health Information as permitted or required.

We may use/or disclose Protected Health Information in our possession for proper management, administration and/or to fulfill any present or future legal responsibilities provided that the disclosures are required by law; or that such uses are permitted under state and federal confidentiality laws; or that we have received assurances of the confidential handling of such Protected Health Information under HIPAA Privacy and Security Regulations.

We will require all subcontractors and agents that perform the services we are obligated to perform under this policy to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to the organization and to us for any Protected Health Information that they received, use or have access to.

Upon termination of this policy, the protections of this policy will remain in force and we shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law.

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PRIOR ACTS CERTIFICATION

If the organization requires "Prior Acts" coverage ("Nose Coverage") for their professional liability exposure, the organization must inform all prior carriers of any incident or circumstances that might lead to a claim being made against the organization. Please provide written documentation that verifies that the organization has informed all prior carriers of such incidents and circumstances. It is not the intent of the Fortress Policy to cover known patient injuries. The organization's prior carriers should cover incidents/claims arising out of these injuries. Please read and sign the following statement.

As an authorized representative of the organization, I certify that I am not aware of any incidents or circumstances, which might result in a claim, except those listed in this application for insurance. I understand that the organization's Fortress Policy will not provide coverage for such incidents of which the organization is aware regardless of whether the organization has reported them to their prior insurance carriers.

Authorized Representative ______________________________ | Title ____________________

Signature ____ | Date ____________________

SUPPLEMENTAL INCIDENT/CLAIM FORM

If additional forms are needed, please photocopy prior to completion.

Patient's Name: ____________________

Organization's Insurance Carrier: ____________________

Please provide verification that this incident/claim has been reported to your prior/current carrier.

Healthcare Provider: ____________________

Healthcare Provider's Carrier: ____________________

Date(s) of Treatment: ____________________

Allegations (if any): ____________________

Present Status: (Check One)

☐ No claim yet made ☐ Claim made, suit not filed

☐ Claim made, suit pending ☐ Claim closed

If this claim has been closed, please note the method of closing and the amount paid (if any):

☐ Suit dismissed or defense verdict ☐ Suit settled $________ ☐ Judgment $________

Description of Incident: ____________________

Please give a complete narrative description. Include the following in the description along with any other information that would be pertinent; attach additional sheets, if necessary.

- Treatment involved
- Result of treatment and the condition of the patient
- The Organization's reply to the allegation

WARNING

Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud. Such person may be subject to denial of insurance benefits, civil penalties and/or criminal penalties.

In CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In NY: 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 each such violation.

In VA: 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.

ACKNOWLEDGEMENT

As an authorized representative of the organization, I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and I have not omitted or withheld any fact or circumstance, which would be relied upon in the determination by Fortress Insurance Company ("Company") in granting liability insurance. I understand that this Application, Supplemental Incident/Claim Form, if included, and any documents provided, are made a part of the policy that is issued. Further, the organization agrees to abide by any recommendations of the Company with regard to loss prevention issues.

As an authorized representative of the organization, I authorize any state board of examiners or licensers, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to the Company or its assigns. I authorize the use of a copy of this Acknowledgement in lieu of its original.

As an authorized representative of the organization, I understand the execution of this application is not a guarantee of coverage and that the Company may, in its sole and absolute discretion, accept or reject this application for professional liability insurance coverage.

This acknowledgement shall be governed and interpreted in accordance with the laws of the state in which this policy is issued.

Authorized Representative ________________________________ Title ________________________

Signature ____ Date ________________________