

FORTRESS INSURANCE COMPANY  
DENTAL PROFESSIONAL LIABILITY APPLICATION



Answers must be typed or printed in ink. Please answer all questions completely. Unanswered questions will delay the process of your application. Use separate sheet of paper if additional space is needed. You must sign and date the application. Signature stamps or the signatures of office personnel are not acceptable. **Students/Residents/New-To-Practice Dentists**: Please answer questions based on your **anticipated future practice**.

1. Effective Date: \_\_\_\_\_ 2. Retroactive Date: \_\_\_\_\_

3. Name: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_ 5. Social Security Number: \_\_\_\_\_

6. Primary Practice Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time Spent at Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

7. Secondary Practice Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time Spent at Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Please list additional practice addresses, with the corresponding percentage of time spent at each location, on a separate sheet of paper.**

8. Mailing Address: (If different than primary practice address.) \_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

9. Do you have a Website?  Yes  No Website Address: \_\_\_\_\_

10. Do you advertise?  Yes  No If yes, please provide a copy of your advertisement(s).

11. **Types of Practice Affiliations** (check all that apply)

A. Individual

B. Employed

Employer's Name: \_\_\_\_\_

C. Independent Contractor

Contractor Name: \_\_\_\_\_

Agent: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

D. Partner of a dental partnership.

Partnership Name (Including any d.b.a.'s "doing business as")

\_\_\_\_\_  
\_\_\_\_\_

E. Shareholder of a dental/professional service corporation.

Corporation Name (Including any d.b.a.'s "doing business as")

\_\_\_\_\_  
\_\_\_\_\_

F. Sole shareholder of a dental/professional service corporation

Corporation Name (Including any d.b.a.'s "doing business as")

\_\_\_\_\_  
\_\_\_\_\_

G. Dental Management Services Organization

Organization Name (Including any d.b.a.'s "doing business as")

\_\_\_\_\_  
\_\_\_\_\_

H. Other

\_\_\_\_\_  
\_\_\_\_\_

**Note: If separate limits are desired for your corporation, please complete a Fortress Organization Application.**

**Coverage for your Sole Shareholder Corporation is provided at no additional charge on shared limits basis only.**

12. Prior practice addresses (List all locations where you have practiced in the last 10 years. Include military service, if applicable.). Please explain any gaps.

Name of Practice	Address	From (Month/Year)	To (Month/Year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. List all previous professional liability insurers for the past 10 years. Please attach a copy of your current Professional Liability Declaration's Page.

Insured	Type (Claims made/Occurrence)	From (M/Yr.)	To (M/Yr.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Please provide the following information for all licenses you hold:

State	License Number
_____	_____
_____	_____
_____	_____
_____	_____

15. Please provide your DEA license number: \_\_\_\_\_

16. Dental associates with whom you practice: **(If more than three associates, please attach a separate page.)**

Name	Affiliation (employee, partner, etc.)	Insurer
_____	_____	_____
_____	_____	_____
_____	_____	_____

17. Education: **(For additional post-graduate education, please attach a separate page.)**

Dental School: _____	Degree: _____	Graduate Date: _____
Post-Graduate Training: _____	Degree: _____	Graduate Date: _____

18. Specialty:  
(Please check one)

_____	General Dentistry	_____	Prosthodontics
_____	Endodontics	_____	Dental Anesthesiology
_____	Orthodontics	_____	Oral Pathology
_____	Pediatric Dentistry	_____	Oral & Maxillofacial Surgery
_____	Periodontics	_____	Other

19. Date you began practice: \_\_\_\_\_

20. Have you attended a risk management seminar from another insurance company within the last three years?  Yes  No

21. Is your practice specialized in any way?  Yes  No  
If yes, please describe: \_\_\_\_\_

22. Do you obtain a dental/medical history on all patients? **(If yes, attach a sample form.)**  Yes  No  
 How often is this information updated?  Every Visit  Quarterly  Annually  Other \_\_\_\_\_
23. Do you obtain written informed consent from your patients? **(If yes, attach a sample for each form utilized.)**  Yes  No
24. Do you or do others administer any sedation/anesthesia other than nitrous oxide and local anesthetic in your practice?  Yes  No

**If yes, please complete the Anesthesia/Sedation Supplement.**

25. Do you have privileges at any hospital?  Yes  No

If yes, please provide delineations of hospital privileges for all hospitals. Hospital delineations must be a list of the specific procedures approved by the hospital within the last two years. These privileges must be signed by the department chair, chief of staff or comparable position.

26. Number of hours per week you practice dentistry: \_\_\_\_\_

27. Approximately how many of the following procedures have you performed in the last 12 months? If none, indicate "0."

_____	Implants – Surgical Placement	_____	Extractions – Impacted Teeth
_____	Orthodontics	_____	Endodontics
_____	Periodontal Treatment - Surgical	_____	TMJ Treatment – Non-Surgical
_____	Oral Examinations		

28. Do you offer treatments outside the standard scope of dentistry, such as, but not limited to, Botox injections, Restylane injections, weight loss appliances or sleep apnea appliances? Dentistry is defined by the ADA as "the specialty of the healing arts which is concerned with the teeth, oral cavity and associated structures, including the diagnosis and treatment of their diseases and the restoration of defective and missing tissue."  Yes  No

**If yes, please complete the Non-Standard Procedure Supplement.**

**Please provide additional detailed narrative for all "Yes" answers to the following questions on a separate sheet.**

29. Are you now or have you ever practiced without professional liability insurance?  Yes  No
30. Have you ever been denied the right to take the dental licensure examination by any state, territory or district?  Yes  No
31. Have you ever had any state professional license or state or federal license to prescribe or dispense narcotics investigated, refused, suspended, revoked, renewal refused or accepted only with special terms; or have you ever voluntarily surrendered the same?  Yes  No
32. Have you ever been charged or convicted of a criminal offense?  Yes  No
33. Have you incurred or become aware of any illness or physical disability that impairs or could impair your ability to practice dentistry?  Yes  No
34. Have you ever been a participant in any drug or alcohol dependency program?  Yes  No
35. Has any insurer ever cancelled your professional liability insurance for any reason, including non-payment of premium, or declined, non-renewed or required you to modify your professional liability coverage (i.e., changed limits, assigned a deductible, restricted coverage, surcharged rates)? **This question does not apply to applicants in Missouri.**  Yes  No

36. Have any fraud charges, including Medicare/Medicaid, ever been filed against you?  Yes  No
37. Have you ever had your membership in a professional society suspended, revoked or refused?  Yes  No
38. Have you ever had your hospital privileges denied, reduced, restricted or suspended?  Yes  No
39. Have you been sued or have any claims been made against you within the past 10 years?  Yes  No
40. If yes, have these claims been reported to your prior/current carrier?  Yes  No

**Please complete a Supplemental Incident/Claim Form for each claim.**

41. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?  Yes  No
42. Do you have any knowledge of any incident that occurred that might give rise to a claim being made against you?  Yes  No
43. If yes, has this incident been reported to your prior/current carrier?  Yes  No

**Please complete a Supplemental Incident/Claim Form for each incident.**

44. Have you ever been involved or affiliated with a situation involving the death of a patient?  Yes  No

**Please complete a Supplemental Incident/Claim Form for each situation.**

45. Please indicate the dental societies of which you are a member.  
 ADA  State Society Indicate State \_\_\_\_\_  Other \_\_\_\_\_
46. Please indicate the type of insurance and limits of coverage you are requesting.

**NOTE: Not all coverage and limits are available in all states.**

**Types of Coverage**

**Limits of Coverage**

**Skip this section if you are in a state with a Patient Compensation Fund.**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Claims-Made | <input type="checkbox"/> \$100,000 per patient/\$300,000 annual total limit                                    |
|                                      | <input type="checkbox"/> \$200,000 per patient/\$600,000 annual total limit                                    |
| <input type="checkbox"/> Occurrence  | <input type="checkbox"/> \$250,000 per patient/\$750,000 annual total limit                                    |
|                                      | <input type="checkbox"/> \$500,000 per patient/\$1,000,000 annual total limit                                  |
|                                      | <input type="checkbox"/> \$1,000,000 per patient/\$3,000,000 annual total limit                                |
|                                      | <input type="checkbox"/> \$2,000,000 per patient/\$6,000,000 annual total limit<br>(Company approval required) |

47. Allied Health Personnel

<u>Type</u>	<u>Employed</u>	<u>Independent Contractor</u>	<u>Total Number</u>	<u>Insurance Carrier</u>	<u>Limits</u>
Dental Assistant	_____	_____	_____	_____	_____
Dental Hygienist	_____	_____	_____	_____	_____
<u>Other - Title</u>	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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**HIPAA STATEMENT**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy and Security Regulations, you are a "covered entity" and we are a "business associate" of yours. 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 you and your practice. 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 you 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 you ask us to provide coverage for "Prior Acts" ("Nose Coverage") for your professional liability exposure, you must inform all prior carriers of any claims, incidents or circumstances that might lead to a claim being made against you. Please provide written documentation that verifies you have informed all prior carriers of such incidents, etc. It is not the intent of the Fortress Policy to cover such known patient injuries. Your prior carriers should cover incidents/claims arising out of these injuries. Please read and sign the following statement.

I certify that I am not aware of any incidents or circumstances, which I might expect to result in a claim, except those listed in this application for insurance. I understand that my Fortress Policy will not provide coverage for such incidents of which I am aware regardless of whether I have reported them to my prior insurance carriers.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**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**

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, and any documents provided are made a part of the policy that is issued. Further, I agree to abide by any recommendations of the Company with regard to loss prevention issues.

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.

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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are requesting consideration of part-time rating, answer the following questions.

- A. Are you a full-time academician?  Yes  No
- B. Are you a full-time student?  Yes  No

If yes to A or B, provide documentation verifying your full-time status and coverage at the institution.

- C. Are you disabled?  Yes  No

If yes, explain your disability (attach additional sheet), and submit medical documentation from your physician.

- D. If you answered "No" to questions A, B and C, provide a detailed explanation regarding your part-time status.

- E. Estimate the total number of hours per average week devoted in your practice to:
  - \_\_\_\_\_ Actual Patient Care
  - \_\_\_\_\_ Administrative Duties
  - \_\_\_\_\_ Actual Patient Record-Keeping
  - \_\_\_\_\_ Educating Dental Students or Residents

- F. Indicate the hours you are available for direct patient care in your office:

Monday	From: _____	To: _____
Tuesday	From: _____	To: _____
Wednesday	From: _____	To: _____
Thursday	From: _____	To: _____
Friday	From: _____	To: _____
Saturday	From: _____	To: _____
Sunday	From: _____	To: _____

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**ACKNOWLEDGEMENT**

I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and belief. I understand that this Part-Time Supplement Form and the answers and statements provided in this application are made a part of any policy that is issued.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_

Your Insurance Carrier: \_\_\_\_\_

**Please provide verification that this incident/claim has been reported to your prior/current 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 your description along with any other information you feel would be pertinent; attach additional sheets, if necessary.

- ◆ Your relationship to the case
- ◆ Treatment involved
- ◆ Result of treatment and condition of patient
- ◆ Your reply to the allegation

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Agent: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

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**ACKNOWLEDGEMENT**

I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and belief, and I understand that prior to my effective date (or retroactive date in the case of a claims-made policy), there is no coverage by the Fortress Policy for any listed claim or incident provided, including dental board investigation. I understand that this Supplemental Incident/Claim Form and the answers and statements provided in this application are made a part of any policy that is issued.

Signature \_\_\_\_\_

Date \_\_\_\_\_

- A. What type of anesthesia/sedation do you provide? (Check all that apply)
- \_\_\_\_\_ Oral Sedation/Single Dose                      \_\_\_\_\_ Intravenous Sedation
- \_\_\_\_\_ Oral Sedation/Multiple Dose
- \_\_\_\_\_ Intra Muscular Sedation                      \_\_\_\_\_ General Anesthesia

B. Describe who administers anesthesia/sedation to your patients and the type of anesthesia/sedation utilized.

\_\_\_\_\_

\_\_\_\_\_

C. Do you perform conscious sedation or general anesthesia to patients other than your own and/or in other locations?  Yes  No

D. Do you prescribe oral sedation agents (Halcion, Triazolpan, Ativan, Valium or similar) for use prior and /or during the patient's scheduled appointment?  Yes  No

A. If yes, do you prescribe to:

- Children  Adults

B. If yes, do you prescribe: (check all that are applicable)

- Single Dose on day of appointment
- Multiple Doses:
- Prior to scheduled appointment
- Prior to and during scheduled appointment
- During the appointment

E. Describe your anesthesia/sedation training: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

F. Please indicate the monitoring equipment used for anesthesia/sedation procedures:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

G. Are you and your practice in compliance with State Board rules and regulations?  Yes  No

H. Please provide a copy of your anesthesia permit, if required by your State.

I. Please provide a copy of your office(s) anesthesia certification(s), if required by your State.

J. Are you currently ACLS certified?  Yes  No

Agent: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

- K. Are you currently BLS certified?  Yes  No
- L. Is your staff BLS certified?  Yes  No
- M. Do you obtain written informed consent for each and all anesthesia/sedation procedures? (If yes, attach a sample for each form utilized.)  Yes  No
- N. Is emergency equipment, including resuscitative equipment, available in your office?  Yes  No
- O. Is a written plan to handle emergencies available in your office, and are all employees/staff trained and familiar with it?  Yes  No
- P. Is anesthesia/sedation provided to children, geriatric or developmentally/mentally compromised individuals?  Yes  No
- Q. Describe your procedures for following up with patients to whom you have administered anesthesia/sedation.

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Signature \_\_\_\_\_

Date \_\_\_\_\_

1. Please indicate the procedures you have performed over the past 12 months. Please identify any "other" procedure you perform that falls outside the scope of dentistry as defined by the ADA. Dentistry is defined by the ADA as **"the specialty of the healing arts which is concerned with the teeth, oral cavity and associated structures, including the diagnosis and treatment of their diseases and the restoration of defective and missing tissue."**

- Blepharoplasty \_\_\_\_\_
- Body Mutilation (Tongue splitting, piercing) \_\_\_\_\_
- Botox \_\_\_\_\_
- Chemical Peels \_\_\_\_\_
- Collagen \_\_\_\_\_
- Dermabrasion \_\_\_\_\_
- Hair Removal \_\_\_\_\_
- Hair Transplantation \_\_\_\_\_
- Laser Skin Resurfacing \_\_\_\_\_
- Cosmetic Micro Pigmentation \_\_\_\_\_
- Obstructive Sleep Apnea Treatment \_\_\_\_\_
- Otoplasty \_\_\_\_\_
- Restylane \_\_\_\_\_
- Rhinoplasty \_\_\_\_\_
- Rhytidectomy \_\_\_\_\_
- Scar Removal \_\_\_\_\_
- Smoking Cessation \_\_\_\_\_
- Tooth Jewelry \_\_\_\_\_
- Weight Loss Programs \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

2. Are these procedures in compliance with your State dental license?  Yes  No

3. Please describe and provide documentation of your training in each procedure indicated above. Include a separate sheet of paper if needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you always obtain written informed consent from your patients for the procedures indicated above?  Yes  No  
**If yes, please provide a sample. If no, please provide an explanation.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: THE PROCEDURES INDICATED ABOVE MAY NOT BE COVERED BY YOUR FORTRESS INSURANCE POLICY.**

Agent: \_\_\_\_\_ Agent License Number: \_\_\_\_\_

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I, the undersigned, hereby declare that all answers and statement herein given are true and complete to the best of my knowledge and belief. I understand that this Non-Standard Procedure Supplement and the answers and statements provided in this application are made a part of any policy that is issued.

I understand that Fortress cannot insure me for procedures performed outside the scope of my state licensure. I understand that it is solely my responsibility to make certain that I am practicing within the scope of my licensure.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_