



# Atlantic Specialty Lines, Inc.

## ALLIED MEDICAL DENTAL PROFESSIONAL SUPPLEMENTAL APPLICATION Submit with Allied Medical General Application

Every statement MUST be completed. Write "NONE" if that applies. PLEASE TYPE OR PRINT.

### SECTION I: GENERAL INFORMATION (To be completed by all applicants) Agent \_\_\_\_\_

1. Full Name \_\_\_\_\_  Male  Female  Date of Birth \_\_\_\_\_  
Last First M.I.

2. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(If different from home address)

4. Home Telephone (\_\_\_\_) \_\_\_\_\_ Professional Degree \_\_\_\_\_ Lic# \_\_\_\_\_ State \_\_\_\_\_

5. I practice as:

Solo Practitioner - UNINCORPORATED Revenue \$ \_\_\_\_\_

EMPLOYEE or INDEPENDENT CONTRACTOR (List name of each employer) \_\_\_\_\_

PARTNERSHIP (List name of partners) \* \_\_\_\_\_

PROF. CORP. or PROF. ASSN. (List name of corp. & principals) \* \_\_\_\_\_

\* All members of a partnership as well as all shareholders of a professional corporation who practice dentistry must be covered under

6. Character of Practice:  General  Endodontics  Oral & Maxillofacial Surgery  Oral Pathology  Orthodontics  
 Pedodontics  Periodontics  Prosthodontics  Other \_\_\_\_\_

### SECTION II: COVERAGE REQUEST

1. Plan of Insurance Desired:

Occurrence  Claims Made  Bridge

2. Requested Limits of Liability:

\$100,000/\$300,000  \$200,000/\$600,000  
 \$500,000/\$1,500,000  \$1,000,000/\$3,000,000

3. Requested Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. \*Requested Retroactive Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*To be completed by all applicants who are leaving an existing claims made program. Refer to the declarations page of your policy to determine the retroactive date.

Attach copy of the current declarations page showing the retroactive date.

5. List Your Professional Liability Insurance carrier for each of the last five (5) years. If none, state NONE.

Inception Date	Expiration Date	Name of Insurance Company	Policy Number	Premium	Limits of Liability

**SECTION III: PRIOR EXPERIENCE**

- Yes  No 1. Has there ever been a claim or suit, settled or pending, made against you for malpractice and/or peer review?  
**If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.**
- Yes  No 2. Do you have reason to believe that your past treatment of, or failure to treat a patient may result in a claim or suit against you or any dentist associated in practice with you?  
**If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.**
- Yes  No 3. Has any claim or suit ever been brought against any dentist associated in practice with you as a result of alleged malpractice, error or mistake?  
**If "Yes," a Supplemental Claim Information Form must be completed for each incident, claim, or suit.**
- Yes  No 4. Have you ever appeared before the state licensing agency for professional misconduct?  
**If "Yes," please provide a copy of the board's findings.**
- Yes  No 5. Has any disciplinary action been taken by or a complaint lodged with, a government agency, hospital, or professional association against you or any of the past or present principals, partners or officers, or any dentist associated with you ?  
**If "Yes," please provide a copy of the complaint and the final order and/or stipulation:**
- Yes  No 6. Have you ever been refused board certification?  
**If "Yes," please give details:** \_\_\_\_\_
- Yes  No 7. Has any insurance company ever declined, failed to renew, or cancelled a Professional Liability Policy for you?  
**If "Yes," please list company, date, and reason:** \_\_\_\_\_
- 8. How many suits for collection of fees have been filed by you during the past two years? \_\_\_\_\_

**SECTION IV: PROFILE OF PRACTICE**

1. How many locations do you practice at? \_\_\_\_\_ Complete the following for each location. **(Space is provided for two (2) locations. If you are involved in more than two (2) locations, please copy as needed.)**

a. Name of Facility \_\_\_\_\_

b. Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

c. County \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

d. What is your professional relationship with this facility? **(Check all that apply)**  
 Owner  Employee  Independent Contractor  Manager  Supervisor  Director  
 Other (please explain) \_\_\_\_\_

e. Time spent at this location: Days per week \_\_\_\_\_ Hours per week \_\_\_\_\_

f. How many dentists, **(excluding yourself)**, are engaged in practice at this location? \_\_\_\_\_

g. For each of these dentists provide their specialty and hours per week spent practicing at this location:

Specialty	Hours per week	Specialty	Hours per week
_____	_____	_____	_____
_____	_____	_____	_____

h. Except as to referrals to specialists, are you solely responsible for the treatment and follow-up care for your patients?  
 Yes  No. **If "No," please explain:** \_\_\_\_\_

a. Name of Facility \_\_\_\_\_

b. Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

c. County \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

d. What is your professional relationship with this facility? **(Check all that apply)**

Owner  Employee  Independent Contractor  Manager  Supervisor  Director

Other (please explain) \_\_\_\_\_

e. Time spent at this location: Days per week \_\_\_\_\_ Hours per week \_\_\_\_\_

f. How many dentists, **(excluding yourself)**, are engaged in practice at this location? \_\_\_\_\_

g. For each of these dentists provide their specialty and hours per week spent practicing at this location:

Specialty	Hours per week	Specialty	Hours per week
_____	_____	_____	_____
_____	_____	_____	_____

h. Except as to referrals to specialists, are you solely responsible for the treatment and follow-up care for your patients?

Yes  **No. If "No," please explain:** \_\_\_\_\_

2. Dental School Attended \_\_\_\_\_ Year Graduated \_\_\_\_\_ Year Licensed \_\_\_\_\_

**Yes**  No      3. Do you employ any dentists as employees or independent contractors?  
**If "Yes," how many?** \_\_\_\_\_

Yes  No      a. Are any of these employees or independent contractors oral and maxillofacial surgeons?

Yes  No      b. Do any of these employees or independent contractors treat patients with general anesthetics, intravenous or intramuscular sedatives?

**Yes**  No      4. Do you rent space to, or otherwise share office space with any dentists who are oral and maxillofacial surgeons, or treat patients with general anesthetics, intravenous or intramuscular sedatives?  
**If "Yes," please explain:** \_\_\_\_\_

Yes  **No**      5. Do you take a written health history on every patient in your practice? **ATTACH A COPY OF THE HEALTH HISTORY FORM USED IN YOUR PRACTICE.**  
**If "No," please explain:** \_\_\_\_\_

**Yes**  No      6. Do you surgically insert fixtures or other types of implants?  
**If "Yes," please complete items a-c below:**

a. How many cases per year? \_\_\_\_\_

**Yes**  No      b. Have you completed a post-doctoral residency program in a hospital or dental school?  
**If "Yes," indicate:**

Type \_\_\_\_\_ Duration \_\_\_\_\_

Year Completed \_\_\_\_\_ Hospital or Dental School \_\_\_\_\_

**Yes**  No      c. Have you completed any surgical training program in the use of implants and fixtures?  
**If "Yes," indicate:**

Year Completed \_\_\_\_\_ Sponsoring Agency \_\_\_\_\_

Duration of Training \_\_\_\_\_

- Yes  No 7. Do you accept **REFERRALS FROM OTHER DENTISTS** for the treatment of patients exhibiting Temporomandibular Joint Dysfunction (TMD)?  
**If "Yes," please explain:** \_\_\_\_\_
- Yes  No 8. Are you licensed or operating as a professional other than a dentist?  
**If "Yes," please describe:** \_\_\_\_\_  
\_\_\_\_\_
- Yes  No 9. Are you on staff, or affiliated in any way with a hospital or clinic?  
**If "Yes," complete the following:**  
Institution \_\_\_\_\_  
Days per Week \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Nature of Duties \_\_\_\_\_
- Yes  No 10. Have you ever experienced, or are you currently experiencing alcoholism, narcotic addiction, or mental illness?  
**If "Yes," please give details:** \_\_\_\_\_
- Yes  No 11. During the past 5 years have you been under the care of a physician?  
**If "Yes," describe why treatment was sought, current status and date of last visit:** \_\_\_\_\_  
\_\_\_\_\_
- Yes  12. Have you ever practiced in any state(s) other than listed in Section I, No. 4?  
**If "Yes," list states:** \_\_\_\_\_
- Yes  No 13. Are you an Oral and Maxillofacial Surgeon?
- Yes  No 14. Do you treat patients who are rendered unconscious **BY YOU OR OTHERS**, through the administering of anesthetics or analgesics **IN A HOSPITAL OR OFFICE**?
- Yes  No 15. Do you provide treatment to any patient who has been sedated with the use of any I.V. or I.M. sedatives?
- Yes  No 16. Do you provide treatment to any patient who has been sedated with the use of general anesthetics?
- Yes  No 17. Do you provide treatment to any patient who has been sedated with nitrous oxide and oxygen?   
 Yes  No **If "Yes," does your equipment have FAIL-SAFE DEVICES?**
- Yes  No 18. Do you use any pre-treatment medication (other than local anesthetics)?  
**If "Yes," describe and indicate drugs used and method of administering:**  
\_\_\_\_\_
- Yes  No 19. Do you use Sargenti Paste in performing endodontic procedures?  
**If "Yes," indicate the number of cases per year:** \_\_\_\_\_

**SECTION V: Dental School Faculty - Premium Credit**

Faculty of duly accredited dental schools are afforded premium credits. If you are a faculty member of such an institution complete this section. **PLEASE SUBMIT A COPY OF YOUR CURRENT LETTER OF APPOINTMENT.**

Name of Dental School \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

On faculty since \_\_\_\_\_ Position/Department \_\_\_\_\_

Days of the Week:     Monday     Tuesday     Wednesday     Thursday     Friday     Saturday

Hours per Day:    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

**SECTION VI: REPRESENTATION AND ACKNOWLEDGEMENT** (To be completed by all applicants)

\* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.  
\* not applicable in all states

**Representation: I represent that the information contained herein is true and that it shall be the basis of the policy of Insurance and deemed incorporated therein, should the company/underwriter evidence its acceptance of this application by issuance of a policy. I further represent that I have not withheld any information which is reasonably likely to influence the judgement of the company/underwriter considering this application (i.e. prior claims, prior difficulties with authorities, prior cancellations or refusals to renew by insurance companies, prior lapses of coverage, etc.). If I have withheld any such information, I understand that my coverage may be voided. I further understand that my failure to disclose any information in my possession regarding possible incidents which may lead to claims will relieve the insurance company of any obligation under Prior Acts coverage.**

**I hereby authorize the insurance company, its agents and representatives to secure claims information from my current and previous insurance carriers.**

**CLAIMS-MADE APPLICANTS ONLY: I have requested my policy be written on a "Claims-Made" form and acknowledge that this policy will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" policy will not provide insurance coverage for claims which occurred prior to the Prior Acts date of my policy.**

**I understand that should my "Claims-Made" policy with this insurance carrier ever be cancelled or non renewed, or I decide to terminate it for any other reason, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy but were not reported to the insurance company before the date of the policy termination, I will be required to purchase additional insurance coverage.**

**SIGNING THIS FORM DOES NOT BIND THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. NO INSURANCE SHALL BE GRANTED UNLESS ALL QUESTIONS ARE ANSWERED AND THE APPLICATION IS SIGNED AND DATED.**

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

Agent Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Agent's License # \_\_\_\_\_