THE DOCTORS COMPANY

CLAIMS-MADE
PROFESSIONAL LIABILITY INSURANCE
EXPRESS APPLICATION FOR FDA SERVICES, INC.

For Dental Professionals

fda services inc.
FLORIDA DENTAL ASSOCIATION SM

FDA Services
1113 E. Tennessee Street
Tallahassee, Florida 32308
(800) 877-7597
insurance@fdaservices.com

THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES.

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant in ink.
3. A copy of your letterhead must be included. Also, please include a copy of all of your "Yellow Pages" advertising, if any.
4. A copy of your curriculum vitae (CV).
5. A copy of your Declarations Page from your current policy, showing your policy period, limits of liability, retroactive date, and coverage summary or any exclusions that were applied to your policy.
6. A copy of your loss runs from all insurance carriers that insured you for the past 10 years (if applicable).
7. A copy of your letterhead and advertisements (if applicable).

I agree that any coverage issued will be contingent upon the truth of the following information:

❑ New Policy Requested Effective Date (mm/dd/yy) ____/____/____ Requested Retroactive Date (mm/dd/yy) ____/____/____

❑ Renewal of Policy Number: _____ ❑ Web Address: _____

PLEASE TELL US ABOUT YOURSELF

1. Full Name: _____ ❑ DDS ❑ DMD ❑ MD ❑ BDS
2. Mailing Address: _____

   City/ State / Zip _____
3. Telephone Number: (_____)_____ 4. Fax Number: (_____)_____ 5. E-mail Address: _____
6. Dental School Attended: _____ 7. Month/Year of Graduation: _____
8. Are you entering practice for the first time? ❑Yes ❑No If "Yes", did you complete a residency? ❑Yes ❑No

   Specialty: _____ Month/year of Completion: _____
9. Date of Birth: _____ 10. Social Security Number: _____-_____-_____ 11. Years in Practice: _____
12. Are you currently licensed to practice dentistry?..... ❑Yes ❑No

    State(s):_____ License #(s):_____
13. How many times have you taken the Dental Board Exam: _____
14. Have you ever failed any portion of the exam? ❑Yes ❑No
    If yes, how many times and explain why: _____

Policy Request Information – Professional Liability

15. Limits Requested: ❑ $250,000 / $750,000 ❑ $500,000 / $1,500,000 ❑ $1,000,000 / $3,000,000 ❑ $1,500,000 / $4,500,000 ❑ $2,000,000 / $5,000,000
    ❑ Other: _____(STATE EXCEPTIONS MAY APPLY)

PLEASE TELL US ABOUT YOUR PRACTICE

16. Under which business structure do you practice?
    ❑ Sole Proprietor ❑ Limited Liability Company ❑ Limited Liability Partnership ❑ Incorporated ❑ Partnership
    ❑ Employee Dentist Name of Employer/Facility: _____ ❑ Employed by Dentist
    ❑ Independent Contractor Name of Employer/Facility: _____

PLEASE TELL US ABOUT YOUR PRACTICE-continued

If you own your practice, please complete the following:

A. Name of your legal entity/corporation (if any): _____

B. Do you desire shared or separate limits of liability to apply to your legal entity?

❑ Shared (limits are shared with you at no cost) ❑ Separate (entity has its own set of limits and an additional charge applies)

C. Excluding yourself, name all officers or partners of your legal entity: _____
(Attach a separate sheet if necessary)

_____

_____

D. Please provide the number of the following who work for you:

❑ Employee dentists (other than yourself and/or partners/corporate officers) * _____

❑ Independent contractor dentists * _____

❑ Other dentists sharing facilities with you who are not covered under this policy) * _____

* NOTE: For any of the ABOVE 3 selections, be sure to attach a separate application or proof of professional liability coverage for each

❑ All other employees (hygienists, assistants, technicians, clerical, etc.) _____

17. Practice Addresses and Percentage of Practice at Each Address (Total of Percentages Must Equal 100%):
Primary

a) _____
Street City County State Zip Code %

b) _____
Street City County State Zip Code %

c) _____
Street City County State Zip Code %

18. Please indicate your average number of practice hours per week that will be covered by this policy including office hours, administrative activities, direct patient care, surgery, consultation, etc. (excluding on-call}: _____

PLEASE TELL US ABOUT YOUR SPECIALTY

19. Indicate your Practice Specialty (please check all that apply)

❑ General Dentistry
❑ Endodontics
❑ Oral/Maxillofacial Surgery
❑ Oral Pathology
❑ Anesthesiology (Dental)-General Anesthesia
❑ Dental Radiologist
❑ Oral Radiology
❑ Orthodontics
❑ Pediatric Dentistry
❑ Anesthesiology (Dental)-Conscious Sedation
❑ Periodontics
❑ Prosthodontics
❑ Public Health
❑ Full-time Faculty-Non-Intramural
❑ Hygienists

PLEASE TELL US ABOUT THE PROCEDURES PERFORMED IN YOUR PRACTICE

20. Which of the following procedures are performed by you or by someone in your practice:

❑ Sleep Apnea Therapy If "Yes", please indicate the following:
❑ I treat only after referral from physician ❑ I treat without physician referral ❑ I fabricate snore guard

❑ "Sargenti," paste fill or formaldehyde based endodontic techniques excluding formocresol primary tooth pulpotomies

❑ Cosmetic dermal procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, dermabrasions, etc.)
If "Yes", please complete the attached Facial Cosmetic Procedure Supplement Form. (Additional premium may be required)

❑ Irreversible TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

❑ Implant Surgery ❑ Extraction of Impacted teeth ❑ Implant Restoration ❑ Molar Endodontics on Permanent Teeth

❑ Sinus Lift Surgery ❑ None of the above

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

21. Anxiety Reduction is defined as "the use of nitrous oxide/oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety."

    Conscious sedation is defined as: "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."

    General Anesthesia and Deep Sedation are defined as: "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 purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof."

    A. Are you treating patients who are under general anesthesia / deep sedation in your office?..... ❑ Yes ❑ No
       If "Yes", who administers the anesthesia? ❑ You ❑ Another Dentist, Anesthesiologist or CRNA
    B. Are you treating patients who are under Conscious Sedation in your office?..... ❑ Yes ❑ No
       Oral Medication? ❑Yes ❑No IV? ❑Yes ❑No
       If Yes, who administers the conscious sedation? You?Another?

PLEASE TELL US ABOUT YOUR DENTAL LABORATORY / DENTAL IMAGING SERVICES

22. Do you operate dental laboratory? ..... ❑ Yes ❑ No
    If "yes" do you accept referrals for other than your patients? ..... ❑ Yes ❑ No

23. Do you provide radiology services for other than your patients or on a referral basis? ..... ❑ Yes ❑ No

PLEASE TELL US ABOUT YOUR PARTICIPATION

24. Are you a member of the Florida Dental Association?..... ❑ Yes ❑ No

PLEASE TELL US ABOUT YOUR LICENSE AND CLAIMS HISTORY

25. A. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? ..... ❑ Yes ❑ No
       If "Yes", provide a copy of the board transcript or other documentation, including resolution.
    B. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? ..... ❑ Yes ❑ No
       If "Yes", provide a copy of the board transcript or other documentation, including resolution.
    C. Have you been convicted of any criminal charges? ..... ❑ Yes ❑ No
       If "Yes", provide details from investigating agency.
    D. Have you ever been or are currently being treated for alcoholism, drug addiction, mental illness or physical impairment? ..... ❑ Yes ❑ No
       If "Yes", provide a letter from treating physician with complete details.
    E. Are you now, or have you ever, practiced without professional liability insurance?..... ❑ Yes ❑ No
       If "Yes", provide details on a separate sheet of paper.
    F. Have you ever had any professional liability insurance refused, cancelled or non-renewed? ..... ❑ Yes ❑ No
       If "Yes", provide details on a separate sheet of paper. THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS
    G. Has any claim or suit for alleged malpractice ever been brought against you? ..... ❑ Yes ❑ No
       If "Yes", please complete Supplemental Claim form.
    H. Are you currently aware of any situation that could lead to a malpractice suit against you? ..... ❑ Yes ❑ No
       If "Yes", please complete Supplemental Claim form.

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

26. List prior insurance carrier(s) for the past three (3) years. If none, state "None."

Insurance Carrier	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability

27. Are you applying for prior acts coverage from The Doctors Company?..... ❑ Yes ❑ No
    If "Yes", please attach a copy of your last declaration page (face sheet).

28. Prior Acts date (Retroactive date) used by your previous carrier_____

29. Was an extended reporting endorsement (tail) purchased form your previous carrier?..... ❑ Yes ❑ No

Supplemental Waiver and Release

I hereby acknowledge that the foregoing information constitutes my application for insurance with The Doctors Company. All statements are my own representations and are true, based upon my personal knowledge of what is reasonably foreseeable from the facts, reasonable inferences or circumstances applicable to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of The Doctors Company in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by The Doctors Company and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by The Doctors Company. I consent to any investigations or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physicians Resource Network, individuals and The Doctors Company. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by The Doctors Company, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for as long as I maintain a business relationship with The Doctors Company, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of The Doctors Company that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to The Doctors Company.

_____ X _____

Date Signature of Applicant

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or The Doctors Company to complete insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

Fraud Statement
Section 817.234(1)(b), Florida Statutes
(if applicable)

The statute requires the statement to contain in substance the following language:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

FACIAL COSMETIC PRODECURE SUPPLEMENT FORM

THE DOCTORS COMPANY

PLEASE COMPLETE THIS FORM IF YOU WISH TO HAVE YOUR POLICY ENDORSED TO REFLECT COVERAGE FOR FACIAL COSMETIC PROCEDURES. (Please contact your agent representative for additional premium information)

I. GENERAL INFORMATION

1. If you are a current policyholder, please indicate your policy number: _____
2. Applicant Name: _____
3. Requested Effective Date (mm/dd/yy): ____/____/____
4. Requested Retro Date (mm/dd/yy): ____/____/____

II. PROCEDURES

1. Do you utilize injectable neurotoxins (i.e. Botox) and/or Dermal Fillers (i.e.Artefill, Collagen Hylaform, Restylane) in your practice? ❑Yes ❑No
   If yes, complete the following:
   a) Total number of patients treated during the last 12 months: _____
   b) Total number of patients estimated to be treated during the next 12 months: _____
   c) Is anyone other than yourself providing neurotoxin injections and/or Dermal Fillers in your office? ❑Yes ❑No
   If yes, please explain:
   _____
   _____
   d) Please indicate all injectable neurotoxins and/or Dermal Fillers utilized in your practice below:

Neurotoxin/ Dermal Fillers	Purpose/Procedure	Used only as approved by the FDA? (Yes or No)	If No, describe off-label usage

2. Do you provide facial cosmetic procedures in a practice other than your own? ❑Yes ❑No
   If yes, please provide address, description of practice, and name of owner:
3. Do you obtain a dental/medical history for all patients? **If yes, attach a sample of each form** ❑Yes ❑No
4. Do you obtain written informed consent for all patients? **If yes, attach a sample of each** ❑Yes ❑No
5. Are you performing these procedures in compliance with your State Dental Practice Act? ❑Yes ❑No
6. Have you ever been the subject of a malpractice claim or suit involving the use of injectable neurotoxins or dermal fillers? ❑Yes ❑No
   If yes, please complete the Claims Supplement Form for each claim

Agent Signature: _____ License Number: _____

III. EDUCATION

1. Please complete the below regarding any training you have received for each injectable neurotoxin and/or dermalfiller and provide copies of all certificates of training/completion you have received:

Date	Course Title	Location	Number of hours completed

Warning

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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 Facial Cosmetic Procedures Supplement Form and the answers and statements provided in this application, if coverage is approved, are made a part of any policy that is issued. I understand that I will be the only dental professional who is provided coverage for the performance of facial cosmetic procedure(s), limited to injectable neurotoxins and dermal fillers by this endorsement if approved. I understand that no coverage will be provided for any other licensed or unlicensed dental or healthcare professional employed or contracted by me or my practice for their performance of facial cosmetic procedure(s) by this endorsement.

Signature _____ Date _____

CLAIM SUPPLEMENT FORM

THE DOCTORS COMPANY

PLEASE COMPLETE A FORM FOR EACH CLAIM/INCIDENT THAT YOU HAVE BEEN INVOLVED IN. IF ADDITIONAL FORMS ARE NEEDED, PLEASE MAKE A PHOTOCOPY PRIOR TO COMPLETION.

PLEASE PROVIDE A LOSS RUN FROM ALL CARRIERS PROVIDING COVERAGE IN THE PAST 10 YEARS

I. GENERAL INFORMATION

1. ❑ Claim ❑ Incident
2. Patient name: _____
3. Date claim/incident occurred: _____
4. Professional liability insurance company involved: _____
5. Date claim/incident was reported to insurance company named above: _____

II. DECRSIPTION OF EVENT

1. Treatment Involved: _____
2. Allegations: _____
3. Outcome of Treatment: _____
4. Name any other dentists or healthcare professionals involved in the treatment of this patient: _____

III. STATUS

1. What is the current status of the claim/incident?
   ❑ Open ❑ Closed on _____ /_____ /_____
2. If closed, please note the method of closing:
   ❑ Claim Settled ❑ Claim Dismissed/Closed with Defense Verdict ❑ Claim Closed with Judgment
3. If closed, please note the amount paid:
   Total Indemnity Paid $_____ Total Expenses Paid: $_____

WARNING

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature_____ Date:_____

Agent Signature_____ License Number: _____