PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®

Professional Liability Renewal Supplement

DEPENDING ON THE COVERAGE YOU ELECT, THE POLICY YOU ARE APPLYING FOR MAY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR DURING AN APPLICABLE EXTENDED REPORTING PERIOD.

Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A. Application must be signed and dated by applicant.
A copy of your letterhead or business card must be included unless your website is up to date and listed below. (N/A if you are an Independent Contractor or Employee Dentist)

Name: **Policy Number:** **Renewal Date:**

Mailing Address: **Phone:** **Website:**

1. **Are you a member of your state dental association or society?** ☐ Yes ☐ No

2. **Have you made any changes to your practice circumstances which have NOT been previously reported to the insurance company:**
   - Changed practice locations ☐ Yes ☐ No
   - Significantly altered the number of hours practiced per week (If 20 hours or less, please complete a Part-Time Supplement) ☐ Yes ☐ No
   - Created a new legal entity or formed a new partnership ☐ Yes ☐ No
   - Entered into a space-sharing arrangement or agreement with another dentist ☐ Yes ☐ No
   - Operate a dental laboratory ☐ Yes ☐ No
   - Render elective cosmetic dermal procedures (including but not limited to Botox, hyaluronic acid products, collagen injections, etc.) ☐ Yes ☐ No
   - Provide holistic dental services ☐ Yes ☐ No

   If **"Yes"** to any of the above or if other changes apply, please describe: ______________________________
   ____

3. **Do you currently offer professional services in a setting other than your office?** .... ☐ Yes ☐ No
   (i.e. spa, residence, school, jail, prison, correctional facility, halfway house or similar type of facility or mobile dentistry of any kind)
   If **"Yes"**, please describe: ______________________________
   ____

4. **IF you own your own practice, please provide the number of the following who work for you (If none, please write "none" or 0):**
   - Employee dentists (other than yourself and / or partners / corporate officers) * ____________
   - Independent contractor dentists * ____________
   - All other employees (hygienists, assistants, technicians, clerical, etc.) ____________

   * **NOTE:** If **NOT** insured with us, please attach proof of current Professional Liability coverage for all your employed and contracted dentists, and other officers or partners of your legal entity.

5. **Which of the following procedures are performed by you (please check all that apply):**
   ☐ **IRREVERSIBLE** TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)

Procedure	Informed Consent Type	Training
☐ Implant Placement/Uncovering/Surgery	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Partially Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Fully Impacted Third Molar Extractions	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Molar Endodontics on Permanent Teeth	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Mini-Implants	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Conscious Sedation	☐ Written ☐ Oral ☐ Both	☐ CE ☐ Dental School ☐ Post Grad ☐ None
☐ Sleep Apnea **without** a referral from a physician		
☐ **None of these**		

6. **EXCLUSIVE of anxiety reduction and conscious sedation, are you treating patients under general anesthesia / deep sedation?**........ ☐ Yes ☐ No
   If **"Yes"**, please answer the following questions:
   Where is the treatment provided? ☐ Your office ☐ Hospital or licensed / regulated surgical center
   IF treatment is provided in your office, please complete the following:
   Who administers the anesthesia? ☐ Yourself ☐ Another Dentist, Anesthesiologist, or CRNA (Please provide proof of current Professional Liability coverage)

7. Have any of the following occurred which have NOT previously been reported to the insurance company?

A professional conduct or fee complaint filed against you with any licensing or regulatory authority	☐ Yes ☐ No
Investigation or action by a governmental agency, including a state licensing board	☐ Yes ☐ No
Medicaid fraud allegation, conviction or related fines against you or your legal entity	☐ Yes ☐ No
Have any of your employees ever had any allegations, convictions, or related fines for Medicaid Fraud?	☐ Yes ☐ No
Have you been charged with or convicted of any criminal charges (including DUI, OWI, etc., not including minor traffic violations)?	☐ Yes ☐ No
Treatment for alcoholism or drug addiction	☐ Yes ☐ No
Diagnosis of physical impairment or mental illness	☐ Yes ☐ No
Involuntary suspension or termination of hospital and/or ambulatory surgical facility privileges	☐ Yes ☐ No
Any situation that could lead to a malpractice suit against you, not already reported	☐ Yes ☐ No

If **"Yes"** to any of the above, please describe: ____

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8. Please provide annual revenues per location *(only if you own your practice and we are providing property insurance for the practice):*

Location 1: ______________________ Location 2: ______________________

Location 3: ______________________ Location 4: ______________________

AUTHORIZATION

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize AAIC to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

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Signature in full Date

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Agent's Signature Date

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

PRE-FILL AGENCY INFORMATION

RETURN TO:

State Administrator Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Phone #: ______________________ Agent's License Number: ______________________

The Professional Protector Plan is a registered trademark of B & B Protector Plans, Inc.. Coverage is underwritten by AAIC.