





- (iii) Root canals? ..... [ ] Yes [ ] No
- (iv) Implants? ..... [ ] Yes [ ] No
- (v) Oral surgery or assisting in oral surgery? ..... [ ] Yes [ ] No  
(Describe) \_\_\_\_\_
- b. Do you administer analgesia? ..... [ ] Yes [ ] No  
If Yes, please list types of analgesia used: \_\_\_\_\_
- 
- c. (i) Do you or an employee of yours administer general anesthesia? ..... [ ] Yes [ ] No  
If Yes, answer (ii) and (iii) below.
- (ii) Is the general anesthesia administered:
1. In a dental office? ..... [ ] Yes [ ] No
  2. In a hospital? ..... [ ] Yes [ ] No
  3. In another type of facility? ..... [ ] Yes [ ] No
- If Yes, please attach explanation.
- (iii) Please list types of general anesthesia used: \_\_\_\_\_
- 
- d. Do you administer general anesthesia to patients of other dentists? ..... [ ] Yes [ ] No  
If Yes, please explain. \_\_\_\_\_
- 
- e. Do you administer anesthesia to non-dental patients? ..... [ ] Yes [ ] No  
If Yes, please give details, including any special training you have pursued to qualify you for this work.  
\_\_\_\_\_
- 
- f. (i) Do you perform any procedures on any patient under general anesthesia? ..... [ ] Yes [ ] No  
(ii) Do you wire jaws closed for diet purposes? ..... [ ] Yes [ ] No  
(iii) Do you do full mouth rehabilitation solely for cosmetic purposes? ..... [ ] Yes [ ] No
- g. If your practice includes plastic surgery, specify percent of practice devoted to:  
traumatic surgery: \_\_\_\_\_ %  
cosmetic surgery: \_\_\_\_\_ %

**5. STAFF**

Category	Number Employed by Applicant	Total Number of Employees	Number Performing General Anesthesia	
			In Office	In Hospital
A. Dentists, General Practice: No surgery (other than gum sutures)				
B. Orthodontists				
C. Oral Surgeons				
D. Nurses				
E. Nurse Anesthetists				
F. X-Ray Technicians, Laboratory Technicians or Dental Technicians				
G. Dental Hygienists (describe duties on back page)				
H. Other (describe) _____				

(NOTE: If you require any of the above to be Named Insureds, separate applications must be submitted for each such employee.)

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**6. PROFESSIONAL AFFILIATIONS**

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- a. Names and indicate location of all hospitals or institutions you now use for your practice and your hospital staff appointments (include city, county, state and federal institutions): \_\_\_\_\_  
\_\_\_\_\_
- b. Are you in the employ of any individual, firm or corporation other than your own?..... [  ] Yes [  ] No  
If Yes, please attach explanation, including details of your responsibilities.
- c. Are you under contract to any individual, firm or corporation other than your own?..... [  ] Yes [  ] No  
If Yes, please attach explanation including details of your responsibilities. If this contact contains a hold-harmless agreement, copy of contact must be attached to application.
- d. Are you in the employ of any governmental entity? ..... [  ] Yes [  ] No  
If Yes, please attach explanation, including details of your responsibilities.
- e. Are you under contract to any governmental entity?..... [  ] Yes [  ] No  
If Yes, please attach explanation, including details of your responsibilities.
- f. (i) Do you advertise your professional services (other than a simple listing in a telephone directory)? ..... [  ] Yes [  ] No  
If Yes, please attach a copy of ALL of your advertisements.
- (ii) Are you associated with any organization that engages in any kind of advertising for, or solicitation of, patients?..... [  ] Yes [  ] No  
If Yes, please attach detailed explanation and a copy of ALL of the advertisements.
- g. Are you a member of, affiliated with, or practicing as a Health Maintenance Organization?..... [  ] Yes [  ] No  
If Yes, please attach explanation.
- h. (i) Do you use a collection agency? ..... [  ] Yes [  ] No  
Name of agency: \_\_\_\_\_
- (ii) Has the agency authority to file suit at its discretion? ..... [  ] Yes [  ] No

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**7. CLAIMS/HISTORY**

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- a. Has any claim or suit ever been brought against you? ..... [  ] Yes [  ] No  
If Yes, please submit a supplemental information form for each claim or suit.
- b. Has any claim or suit ever been brought against any of your partners, members of your professional association or professional corporation, or your employees on account of alleged malpractice, error, or mistake?..... [  ] Yes [  ] No  
If Yes, please attach name of your malpractice insurer, date of incident, year suit instituted or claim made, claimant, allegations of the claim, status of disposition, and amount paid or currently reserved.
- c. (i) Are you aware of any acts, error, omissions or circumstances which may result in malpractice claim or suit being made or brought against you?..... [  ] Yes [  ] No
- (ii) Are you aware of any acts, error, omissions or circumstances which may result in a malpractice claim or suit being made or brought against any of your partners, members of your professional association or professional corporation, or your employees? ..... [  ] Yes [  ] No  
If Yes to either (i) or (ii) above, please attach details.
- d. Have you ever been:
- (i) the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ..... [  ] Yes [  ] No
- (ii) convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... [  ] Yes [  ] No
- (iii) treated for alcoholism or drug addiction?..... [  ] Yes [  ] No
- IF ANY ANSWER FOR THE ABOVE IS YES, PLEASE ATTACH DETAILED EXPLANATION, INCLUDING DATES.

e. Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or have you have voluntarily surrendered same?.....[  Yes [  No  
 If Yes, please attach explanation.

f. Have you ever failed any dental licensing or specialty organization examination? .....[  Yes [  No  
 If Yes, please attach detailed explanation including dates and locations.

g. Please list professional liability insurance for each of the past four years (IF NONE, STATE NONE).

Insurance Co.	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retroactive Date
							Yes	No	
_____	_____	_____	_____	_____	_____	_____	[ <input type="checkbox"/> ]	[ <input type="checkbox"/> ]	_____
_____	_____	_____	_____	_____	_____	_____	[ <input type="checkbox"/> ]	[ <input type="checkbox"/> ]	_____
_____	_____	_____	_____	_____	_____	_____	[ <input type="checkbox"/> ]	[ <input type="checkbox"/> ]	_____
_____	_____	_____	_____	_____	_____	_____	[ <input type="checkbox"/> ]	[ <input type="checkbox"/> ]	_____

h. Has any insurance company or Lloyd's ever canceled, declined, refused to renew or accepted your malpractice insurance only on special terms? .....[  Yes [  No  
 If Yes, please give details. \_\_\_\_\_  
 \_\_\_\_\_

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and 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 Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

\_\_\_\_\_  
 Name of Applicant

\_\_\_\_\_  
 Title (Officer, partner, etc.)

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

**SUPPLEMENTAL CLAIM INFORMATION**

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.  
 (PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

1. Applicant Name \_\_\_\_\_
2. Claimant Name \_\_\_\_\_
3. Name of Individual(s) at your firm/Company involved in Claim: \_\_\_\_\_
4. Indicate whether: \_\_\_\_\_ Claim/Suit \_\_\_\_\_ Incident
5. Date of alleged error: \_\_\_\_\_ Date claim made against applicant: \_\_\_\_\_
6. Additional defendants: \_\_\_\_\_
7. Current Disposition of claim:
  - DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
  - ABANDONED (no activity from claimant for over 3 years)
  - WON by defense
  - WON by claimant      Total Paid \$ \_\_\_\_\_      Amount Paid on your behalf \$ \_\_\_\_\_
  - Indicate whether :  Court judgment, or  Out of court settlement
  - OPEN Claimant's settlement demand \$ \_\_\_\_\_
  - Defendant's offer for settlement? \$ \_\_\_\_\_      Insurer's loss reserve \$ \_\_\_\_\_
8. Name of Insurer: \_\_\_\_\_
9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
  - a. Alleged act, error or omission upon which Claimant bases claim: \_\_\_\_\_
  - b. Description of cases and events: \_\_\_\_\_
  - c. Description of the type and extent of injury or damage allegedly sustained: \_\_\_\_\_
  - d. If a medical claim provide type of injury claimed:
    - Emotional Only       Temporary Disability       Death       Cosmetic
    - Permanent Disability       Other (describe) \_\_\_\_\_
10. Explain what action has been taken by you to prevent recurrence of the same type of claim. \_\_\_\_\_

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

\_\_\_\_\_  
 Name of Applicant\*

\_\_\_\_\_  
 Title (Officer, partner, etc.)

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

\*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.

- o DEERFIELD INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY

**MEDICAL INCIDENT OR THREAT OF CLAIM FORM  
 FOR PHYSICIAN, SURGEON, DENTIST & PODIATRIST APPLICATIONS**

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. This is a mandatory form which must accompany a completed application and supplemental claim information form.
3. PLEASE READ THE STATEMENTS AT THE END OF THIS APPLICATION CAREFULLY.  
 (PLEASE TYPE OR PRINT IN INK)

**1. NAME OF APPLICANT**

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**2. APPLICANT HISTORY**

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- a. Are you aware of any act, error, omission or circumstance which could result in a malpractice claim or suit being made against you? .....[ ] Yes [ ] No  
 If Yes, has this been reported to a prior carrier? .....[ ] Yes [ ] No  
**SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such medical incident or threat of claim;** have you attached the completed form? .....[ ] Yes [ ] No
- b. To the best of your knowledge, have any of the following adverse results occurred in your practice in the last (5) years:
- (i) Unexpected death (including stillbirths)? .....[ ] Yes [ ] No
  - (ii) Unexpected organ failure or significant neurological or functional deficit? .....[ ] Yes [ ] No
  - (iii) Failure to diagnose cancer or infection resulting in death or disability of patient? .....[ ] Yes [ ] No
  - (iv) Tear or perforation of an organ or body part during an invasive procedure, or unplanned removal of a normal organ or body part during an operative procedure? .....[ ] Yes [ ] No
  - (v) Suspicious or positive x-ray, Pap smear or mammogram where patient was not contacted? .....[ ] Yes [ ] No
  - (vi) Follow-up/emergency surgery, myocardial infarction or cerebral vascular accident within **48 hours** of your previous diagnostic treatment or surgery? .....[ ] Yes [ ] No
  - (vii) Complications from improper medication or improper dosage? .....[ ] Yes [ ] No
  - (viii) Pathological and/or operative report which do not match? .....[ ] Yes [ ] No
- If yes to any of the above, has it been reported to a prior carrier? .....[ ] Yes [ ] No  
**If you have NOT reported to a prior carrier, please attach an explanation.**  
**SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result;** have you attached the completed form? .....[ ] Yes [ ] No
- c. Has any attorney contacted you (e.g., request for medical records) in connection with any patient that has NOT been disclosed to us? .....[ ] Yes [ ] No  
 If yes, **SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result;** have you attached the completed form? .....[ ] Yes [ ] No
- d. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney? .....[ ] Yes [ ] No
- e. Has any prior professional liability carrier refused coverage for, or declined to accept your report of, a medical incident, threat of claim, adverse result or attorney contact? .....[ ] Yes [ ] No  
 If yes, please attach an explanation.

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

\_\_\_\_\_  
 Name of Applicant\*

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

\*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.