FAX COVER

To: Joe Ray IV

From:_________________

Phone:________________

Complete this form and fax to 614.459.4509

Notes:

Please note: sending this application does not bind Ray Insurance to provide insurance; however, this application will be the basis of the contract should a policy be issued.

SECTION I – GENERAL INFORMATION

1. How is the policy named insured to read?______________________________
   Is this an ☐ individual ☐ partnership ☐ corporation ☐ LLC ☐ LLP ☐ other: ______________
2. Mailing Address:______________________________
   ____
   Office Address: ______________________________
   Cell Phone No.:(   )____________________ Work Phone No.______________
   e-mail Address: ____________________ Web Address:______________

SECTION II – DENTIST INFORMATION – SEPARATE APPLICATION TO BE COMPLETED BY EACH DENTIST

1. Name of applicant:____________________ Date of Birth:______________
2. List university or college from which you graduated:______________
   Degree:__________ Year:______ Date you received state or regional board certification:______
3. State(s) you are licensed in:______________(License No. ______________)
4. State(s) that you practice in:______________(IN only Professional License No. __________)
5. Are you a specialist? ☐ Yes ☐ No If "Yes", please describe:______________
   School certified by:____________________Date certified:______________
6. Do you meet the continuing education requirements of your state? ☐ Yes ☐ No If "No", please explain in the space provided for "Remarks".
7. How many total hours per week at all locations, do you practice?______________
8. If employed, by whom and in what capacity?______________

SECTION III – CLAIMS INFORMATION

Please fully explain any "Yes" answers to the following questions in the space provided for "Remarks".

		Yes	No
1.	Have you or any of your employees had a claim made or suit brought for actual or alleged malpractice, error or mistake in the past five years?............	☐	☐
2.	During the past five years, has any insurer cancelled any similar insurance issued to you or declined to issue such insurance?............	☐	☐

SECTION IV – COVERAGE INFORMATION

1. Effective dates: From:____________________ To:______________
2. Please indicate limits of insurance by checking appropriate option:
   - ☐ A $1,000,000 / 1,000,000
   - ☐ B $1,000,000 / 2,000,000
   - ☐ C $1,000,000 / 3,000,000
   - ☐ D $2,000,000 / 4,000,000
3. Is your expiring policy a "claims-made" policy? ☐ Yes ☐ No If "Yes", prior acts coverage may be needed.
4. a. Do you desire prior acts coverage? ☐ Yes ☐ No If "Yes", please complete Section VII.
   b. if "No", have you purchased an extended reporting period endorsement from your prior carrier?
   ☐ Yes ☐ No
5. Is excess liability coverage (umbrella) desired? If "Yes" a separate application may be required.
   - ☐ A $1,000,000
   - ☐ B $2,000,000
   - ☐ C $3,000,000
   - ☐ D $4,000,000
   - ☐ E $5,000,000

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SECTION V – PRACTICE INFORMATION

1. **Please fully explain any "Yes" answers to the following in the space provided for "Remarks":**

	Yes	No
a. Has any dental or state licensing authority ever revoked, suspended or imposed any restrictions on your license, disciplined you or placed you on probation?....................	☐	☐
b. Do you have any current hospital staff appointments or privileges?............................	☐	☐
c. Have you had hospital privileges granted, denied or revised?.....................................	☐	☐
d. Has your membership in a dental association ever been revoked or suspended?.........	☐	☐
e. Do you perform any procedures which have been introduced to the practice of dentistry within the last two years?..	☐	☐
f. Have you ever had a case brought against you in peer review?..................................	☐	☐
g. Have you ever voluntarily surrendered or had a DEA license refused, suspended, or revoked?...	☐	☐

2. Does your office comply with the following OSHA and ADA guidelines for infection control?
   ☐ Yes ☐ No If "No", please explain in space provided for "Remarks".
   a. Do you autoclave or heat sterilize equipment after each patient? ☐ Yes ☐ No If "No", explain in space provided for "Remarks".
   b. Do you wear surgical gloves, mask, gown and protective eyeware for all patient care? ☐ Yes ☐ No If "No", explain in space provided for "Remarks".
3. Are you a member of a local, state or national dental association? ☐ Yes ☐ No
   If "Yes", please list name of association:____
4. a. Dentist procedure checklist. Indicate the percentage of time devoted to the following activities and check the techniques or procedures you perform. **Percentage must add up to 100%. Please do not list 100% General Dentistry.**

%	Activity		
%	Endodontics	Do you treat only single rooted teeth? ☐ Yes ☐ No	
		Do you treat multi-rooted teeth? ☐ Yes ☐ No	
		Do you use Sargenti paste / cement? ☐ Yes ☐ No	
%	Pedodontics		
%	Orthodontics	**Check appropriate Procedures / Cases Treated**	
%	Periodontics		Gingivitis
			Slight Periodontis
			Moderate Periodontis
			Osseous Surgery
			Advanced Periodontis
			Refractory Progressive Periodontis
%	Prosthodontics		Removable
			Fixed
%	Surgery		Orthognathic surgery
			Reducing fractures
			Traumatic surgery – please explain on last page.
			Other – Please describe in space provided for Remarks".
%	General Dentistry (including simple extractions, but not procedures listed above)		
%	Other, please describe:		
100%	TOTAL		

1. 1. Do you extract third molars? ☐ Yes ☐ No
   If yes, (a) Erupted ☐ Yes ☐ No
   (b) Impacted, soft tissue ☐ Yes ☐ No
   (c) Impacted, other than soft tissue ☐ Yes ☐ No
   2. Do you perform oral cancer examinations? ☐ Yes ☐ No

5. Check the following additional dental techniques or procedures you perform:
   a. Prosthetic implants ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks"
   b. Surgical implants ☐ Yes ☐ No If "Yes", please complete Section **VIII**.
   c. Treatment of Tempromandibular Joint (TMJ) disorders ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks"
   d. Laser surgery on soft tissue ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks"
   e. Laser surgery on hard tissue ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks"
   f. Dermal fillers (Botox, Restylane) ☐ Yes ☐ No If "Yes", please describe in space provided for "Remarks"
6. a. Do you utilize professional independent contractors in your practice? ☐ Yes ☐ No
   If "Yes", please explain your working relationship in the "Remarks" section of this application.
   If "Yes", a certificate of insurance with a minimum limit of $1,000,000 is required from the independent contractor.
   b. Does the independent contractor perform procedures beyond the scope that you perform?
   ☐ Yes ☐ No If "Yes", please explain in the "Remarks section of this application.
7. Number of professional employees in the following categories:

	Dentists (attach separate application for each)
	Hygienists
	Dental Assistants
	E.F.D.A.s
	A.Q.P.
	Anesthesiologists / Anesthetists
	Others, please describe:

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SECTION VI – ANESTHETIC AND OTHER INFORMATION

1. Do you utilize any of the following anesthesia?
   a. Local anesthesia or inhalation sedation (N^2O)……………………… ☐ Yes ☐ No
   b. Oral sedation……………………………………………………………………… ☐ Yes ☐ No
   c. Intravenous conscious sedation (IV)…………………………………… ☐ Yes ☐ No
   d. Intramuscular sedation *(IM)……………………………………………… ☐ Yes ☐ No
   e. General anesthesia (includes sleep sedation)……………………… ☐ Yes ☐ No
   * If "Yes", is IM or general anesthesia administered in the hospital only? ☐ Yes ☐ No
   Do you, an employee of yours or a trained anesthetist administer the general anesthesia or intramuscular sedation? ☐ Self, Employee ☐ Anesthetist – Independent Contractor
2. Describe IV training and courses taken:____
3. Do you consult with the patient's primary care physician on underlying health conditions; i.e., diabetes, heart, existing infections, etc.? ☐ Yes ☐ No
   If "No", please explain in space provided for "Remarks".
4. Do you obtain a complete medical history on all patients? ☐ Yes ☐ No How often is the information updated?____
   If "No", please explain in space provided for "Remarks".
5. Do you obtain a patient "informed consent" form? ☐ Yes ☐ No If "Yes", explain on last page the procedures for which you obtain the form.
   If "No", please explain in the space provided for "Remarks".

SECTION VII – PRIOR ACTS COVERAGE: COMPLETE THIS SECTION ONLY IF YOU ANSWERED "YES" TO SECTION IV, No. 5.

If you are applying for prior acts coverage, please answer the following questions.

1. History of Professional Insurance – Complete the following for the last five-year period:
   Professional Coverage – Primary and Umbrella (Excess)

Policy Term	Name of Carrier	Limit Each Claim / Agg.	Claims – Made	Retro Date

2. Do you know any circumstances, acts, errors or omissions which could result in a professional liability claim? ☐ Yes ☐ No If "Yes", describe fully in space provided for "Remarks", and indicate if prior carriers have been notified.
3. Prior acts coverage to be effective – From:______________________________ (retroactive date)
4. Please indicate the limits of insurance requested for the prior acts period.
   Each Incident $________________ Aggregate $________________

SECTION VIII – IMPLANT INFORMATION – COMPLETE IF PERFORMING SURGICAL PLACEMENT OF IMPLANTS

1. Describe the formal training you have received in implantology. Attach description of courses you attended, dates the courses were held and name and location of teaching entity. Include a list of continuing education courses you have attended in the past two years.______________________________
____
____
2. Has your training in implantology been classroom, hands-on or both?______________________________
3. When did you first start placing implants?____
4. What type of implants do you place?
   a. Endosteal ☐ Yes ☐ No
   b. Subperiosteal ☐ Yes ☐ No
   c. Other (please describe):____
   ____
   ____
5. How many implants have you placed over the past 24 months and how many implant patients did you treat during the same period?____
____
6. How many patients do you estimate placing implants in over the next 24 months?____________________
7. Attach copies of the informed consent form and patient education material you utilize prior to placing implants.
8. What criteria do you use in selecting patients for implants?______________________________
____
____

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SECTION IX– SUPPLEMENTAL INFORMATION

CLAIM INFORMATION

1. Name of patient / claimant:__________________ 2. Date of treatment to allegation:________________
3. Allegation:____
   ____
4. Date of cliam / suit__________________ 5. Additional defendents______________________________

5a. Claim reported to prior carrier ☐ yes ☐ no
5b. Name of insurer____
6. Current disposition: open___________ Amount of reserve $____________________
   closed______________Amount of settlement of judgment $_________________
   if no payment, was claim / suit withdrawn ☐ yes ☐ no

Please provide a narrative description of the case, including nature of treatment, your involvement, etc.

____
____
____
____

Remarks
Section Number/
Question Number Explanation

NOTE TO APPLICANT: PLEASE READ CAREFULLY

You agree that signing this application does not bind Ray Insurance to provide the insurance; however, this application will be the basis of the contract should a policy be issued. You certify that reasonable inquiry has been made to obtain the answers given in the application and that this application has been completed in a true, correct and complete manner to the best of your knowledge and belief. You also certify that you are duly registered and licensed to practice your profession under the laws of all jurisdictions of which you practice.

WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 SUJECTS (VT: MAY BE COMMITING A CRIME SUBJECTING) THE PERSON TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES. IN THE DISTRICT OF COLUMBIA, LOUISIANA, MAINE, TENNESSEE AND VIRGINIA, INSURANCE BENEFITS MAY ALSO BE DENIED.

NOTICE TO OHIO APPLICANTS; ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE / SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

______________________________ ____________________

Applicant’s Signature **Date**

______________________________ ____________________

Agent’s Signature **Date**