



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 this policy. A separate application must be submitted for each practitioner.

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 a 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
- Yes  No
- Yes  No
- 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.**
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.**
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.**
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:** \_\_\_\_\_



**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 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.**

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 nonrenewed, 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 # \_\_\_\_\_



## ALLIED MEDICAL GENERAL APPLICATION

### APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:			
MAILING ADDRESS:			
CITY, STATE, ZIP:			
COUNTY:		PHONE NUMBER:	
INSPECTION CONTACT:		DATE ESTABLISHED:	
YEARS IN BUSINESS UNDER CURRENT MGMT:			
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____		
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Type of Operation:	<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Shelters <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Halfway House <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Apartments <input type="checkbox"/> Other (specify) _____		
Full description of services rendered:	_____ _____ _____		

<b>Current Insurance:</b>			
Has applicant had previous insurance for this enterprise?			<input type="checkbox"/> No <input type="checkbox"/> Yes
If "Yes," complete the following:			
General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro date if Claims Made		Retro date if Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? If "Yes," complete the following (use a separate sheet if necessary):  No  Yes

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim?  No  Yes  
 If "Yes," provide full details: \_\_\_\_\_  
 \_\_\_\_\_

Has any license or accreditation ever been suspended, denied or revoked?  No  Yes  
 Of what professional association(s) is Insured a member in good standing? \_\_\_\_\_

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation:

Criminal Background Checks  Verification of certification or professional licensing  
 Drug, alcohol and sexual abuse screening or testing  Reference Checks  
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Schedule of Physicians – on Staff or Contracted:					
Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want the physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain: _____					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If "Yes," how many per year? _____					<input type="checkbox"/> No <input type="checkbox"/> Yes

**Schedule of Location:** (if more than three locations, attach a separate sheet of locations)

#1 Address	
Types of Services Provided	

#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	

Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes

<input type="checkbox"/> Residential or Inpatient – <b>complete supplemental application</b>
<input type="checkbox"/> Foster Care or Adoption – <b>complete supplemental application</b>

<b>Check the coverages and limits that the applicant would like quoted:</b>				
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)	<input type="checkbox"/> Excess _____ (attach acord app)
	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500	
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3	
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?				
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300	
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> Other _____	

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**Please attach a copy of the following with your submission:**

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: [www.colonyins.com](http://www.colonyins.com)
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.