SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

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

DENTISTS PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full Name of Individual Applicant:_____ Professional Degree:_____

b. Applicant's Date and Place of Birth:_____ Social Security #: _____

c. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

d. Secondary Locations: _____

_____

e. Business Phone: ( ) _____ Home Phone: ( ) _____

Federal DEA #: _____

f. Are you a U.S. citizen? [ ] Yes [ ] No
If No, please indicate your status and your date of entry into the U.S.A. on a separate sheet.

g. Requested Limits: _____ (per claim) _____ (agg.) _____ Deductible Effective Date _____

h. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [ ] Yes [ ] No
If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

2. YOUR EDUCATION

a. Dental School: _____ Graduation Date: _____

Location: _____
(City) (State) (Country)

b. Internship at (include location): _____

During the years _____

Residency at (include location): _____

During the years _____

c. Have you participated in continuing education within the past five years? [ ] Yes [ ] No If yes, please attach details.

3. YOUR PRACTICE

a. [ ] Solo Practitioner (unincorporated)
[ ] Professional Assoc.
[ ] Solo Practitioner (incorporated) [ ] Partnership
[ ] Employee of _____
(give name)
[ ] Professional Corp
[ ] Other (describe) _____

b. For all applicants BUT employees and unincorporated solo practitioners:

(i) Please list the names of ALL partners, employees, or members of your professional association or corporation who practice medicine: _____

(ii) The formal corporate, association, partnership or business name: _____

(iii) Please attach a copy of your letterhead.

(iv) Are applications being submitted for each individual listed in Question b(i) above? [ ] Yes [ ] No If No, attach explanation.

c. States in which you are registered and licensed to practice:

State	License #

d. Where have you practiced your profession since residency?
In _____ during the years _____
In _____ during the years _____
In _____ during the years _____

e. Dental Specialty (CHECK ONE)
[ ] General Dental Practice [ ] Orthodontics
[ ] Oral Surgery [ ] Anesthesiology
[ ] Other (describe)_____

f. Do you have any other professional specialty? [ ] Yes [ ] No If Yes, please describe _____
_____

g. Do you anticipate taking any additional residencies or changing your specialty? [ ] Yes [ ] No If Yes, please attach explanation.

h. Approximate number of patient encounters ANNUALLY: _____
Approximate number of hours worked weekly: _____

i. Approximate gross annual income from the practice (check one):
[ ] less than 20,000 [ ] 80,000 to 99,000
[ ] 160,000 to 179,999 [ ] 20,000 to 39,999
[ ] 100,000 to 119,999 [ ] 180,000 to 199,999
[ ] 40,000 to 59,000 [ ] 120,000 to 139,999
[ ] 200,000 or more [ ] 60,000 to 79,999
[ ] 140,000 to 159,999 please estimate_____

4. PROCEDURES

a. Do you perform:

(i) Orthodontics?.....[ ] Yes [ ] No

(ii) Extractions of impacted teeth?.....[ ] Yes [ ] No

(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.)

6. PROFESSIONAL AFFILIATIONS

a. Names and indicate location of all hospitals or institutions you now use for your practice and your hospital staff anointments (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 contact 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 king 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

7. CLAIMS/HISTORY

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? Yes	No	Retroactive Date
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	

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.

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Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY

(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: