# Fortress Insurance Company
# Dental Professional Liability Application

PLEASE INDICATE THE TYPE OF COVERAGE REQUESTED: ☐ INDIVIDUAL COVERAGE ☐ ENTITY COVERAGE ☐ BOTH

## I. General Information

1. Name: _____ Suffix: ☐ DDS ☐ DMD ☐ Other _____
2. Date of Birth: _____ Social Security #: _____
3. Practice Address: _____
   City: _____ County: _____ State: _____ Zip: _____
   % of time spent at location: _____%
   **Please provide all additional locations requiring Fortress coverage on page 4 of the application**
4. Mailing Address (If different than practice address): _____
   City: _____ County: _____ State: _____ Zip: _____
5. Billing Address (If different than practice address): _____
   City: _____ County: _____ State: _____ Zip: _____
6. Office Phone: _____ Office Fax: _____ Home Phone: _____
   Email Address: _____ Website Address: _____

## II. Coverage Information

1. Requested Effective Date: _____
2. Coverage Type: ☐ Claims-Made ☐ Occurrence
3. If Claims-Made coverage is requested, please indicate if prior acts coverage is desired: ☐ Yes ☐ No
   If yes, please indicate your Retroactive Date: _____
   **Please submit your current professional liability declarations page**
4. Limits Requested (each person/aggregate limit): ☒ $250,000/$750,000
5. Please list all of your previous professional liability insurers for the past 10 years:

| Insurance Company | Coverage Type | From (Month/Year) | To (Month/Year) |
|---|---|---|---|
| _____ | ☐ Claims-Made ☐ Occurrence | _____ | _____ |
| _____ | ☐ Claims-Made ☐ Occurrence | _____ | _____ |
| _____ | ☐ Claims-Made ☐ Occurrence | _____ | _____ |

6. Are you now or have you ever practiced without professional liability insurance? ☐ Yes ☐ No
   If yes, please explain: _____
7. Has any insurer ever cancelled your professional liability insurance for any reason including non-payment of premium or non-renewal? **If yes, please include a copy of the notice of cancellation** ☐ Yes ☐ No
8. Has your professional liability insurance ever been restricted or limited in any way? ☐ Yes ☐ No
   If yes, please explain: _____
9. Do you have an active professional liability policy to cover a practice location for which you are not requesting Fortress coverage? ☐ Yes ☐ No
   **If yes, please include proof of coverage and provide list of practice locations on page 4 of the application**

## III. Education & Licensure

1. Dental School: _____ Degree: _____ Year Graduated: _____
   Post-Graduate Training: _____ Degree: _____ Year Graduated: _____
   **Please do not abbreviate the institution's name**
2. Please indicate the professional organizations of which you are a member:
   ☐ ADA ☐ AGD ☐ _____ State Association ☐ Other_____
3. Please indicate your Specialty:
   ☐ General Dentistry ☐ Dental Anesthesiology ☐ Oral & Maxillofacial Surgery
   ☐ Endodontics ☐ Orthodontics ☐ Oral & Maxillofacial Radiology
   ☐ Pediatric Dentistry ☐ Periodontics ☐ Oral & Maxillofacial Pathology
   ☐ Prosthodontics ☐ Dental Public Health
4. Please provide the following information for all active and inactive professional licenses you possess:

| Type (Dental, DEA etc) | State | License # |
|---|---|---|
| Type (Dental, DEA etc) | State | License # |
| Type (Dental, DEA etc) | State | License # |

5. Have you attended a risk management seminar in the last three years? ☐ Yes ☐ No
   **If yes, please attach a certificate of completion**
6. Have you ever been denied the right to take a dental licensure examination by any state, territory, or district? ☐ Yes ☐ No
   **If yes, please explain on page 4 of the application**
7. Has your state dental license or federal DEA license ever been subject to investigation by the Board of Dentistry or any other administrative body? ☐ Yes ☐ No
   **If yes, please submit a detailed narrative of events and a copy of all pertinent documentation**
8. Has your state dental license or federal DEA license ever been disciplined including, but not limited to, revocation, suspension, probation or subject to a fine? ☐ Yes ☐ No
   **If yes, please submit a detailed narrative of events and a copy of all pertinent documentation**

## IV. Practice Information

1. Please provide each location in which you have practiced in the last 10 years:

| Name of Practice | City/State | From (Month/Year) | To (Month/Year) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

   **If additional space is needed, please utilize page 4 of the application**
2. Please indicate all location types for which you are requesting coverage:
   ☐ Dental Office ☐ Nursing Home ☐ Mobile Dental Unit
   ☐ Government Office ☐ Hospital ☐ Imaging Facility
   ☐ Surgi-Center ☐ Dental Laboratory ☐ Other _____
3. Please indicate the average number of patients seen per week for which you require Fortress coverage: _____
4. Please indicate the average number of hours you practice per week for which you require Fortress coverage: _____
5. If you practice on average less than 20 hours per week/1,000 hours per year as stated in question #4 above, are you requesting part time coverage? ☐ Yes ☐ No
   **If yes, please explain why your practice is limited on page 4 of the application**
6. Are you involved in the teaching or training of any dental students or dental professionals? ☐ Yes ☐ No
   If yes, please complete the following:
   a. Name of institution: _____
   b. Does the institution provide professional liability coverage for this activity? ☐ Yes ☐ No

7. Do you obtain a dental/medical history for all patients? **If yes, attach a sample of each form** ☐ Yes ☐ No
8. Do you obtain written informed consent for all patients? **If yes, attach a sample of each form** ☐ Yes ☐ No
9. Do you have privileges at any hospital? **If yes, please submit a delineation of privileges** ☐ Yes ☐ No
10. Do you administer any sedation/anesthesia in your practice? ☐ Yes ☐ No
    If yes, please mark all that apply to your practice:
    ☐ Local Anesthesia ☐ Nitrous Oxide ☐ Multi-Dose Oral Sedation
    ☐ PO/Enteral — Minimal Sedation ☐ IV/IM — Moderate Sedation ☐ General Anesthesia – Deep Sedation
    ☐ Sedation/anesthesia to patients other than your own
    ☐ Sedation/anesthesia to special needs patients
11. Please indicate each individual other than yourself that administers sedation/anesthesia other than nitrous oxide and local anesthetic in your practice:
    ☐ CRNA ☐ Dental Anesthesiologist ☐ Medical Anesthesiologist ☐ Other _____
12. How many of the following procedures do you intend to provide on an annual basis:
    Surgical Placement of Implants _____ Extractions of Impacted Teeth _____
13. Do you provide treatment for Obstructive Sleep Apnea (OSA)? ☐ Yes ☐ No
    If yes, please complete the following:
    a. Do you obtain referral from the patient's physician before treating? ☐ Yes ☐ No
    b. Does your treatment include a surgical procedure? ☐ Yes ☐ No
    **If yes, please explain procedure on page 4 of the application**
14. Do you perform any procedures unrelated to the diagnosis and treatment of teeth and the oral cavity? ☐ Yes ☐ No
    **If yes, please submit a detailed explanation of the procedure, the quantity performed and the purpose of the procedure on page 4 of the application**
15. Do you utilize injectable neurotoxins (i.e. Botox) and/or Dermal Fillers (i.e. Artefill, Collagen, Hylaform, Restalyne) in your practice? ☐ Yes ☐ No
    **If yes, please complete the Facial Cosmetic Procedure Supplement to apply for coverage. Please note coverage may not be available in all states.**
16. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA Approved? ☐ Yes ☐ No
    **If yes, please explain the programs on page 4 of the application**
17. Do you utilize any advanced CT imaging scans in your diagnosis and treatment planning? ☐ Yes ☐ No
    If yes, are the results read by a radiologist? ☐ Yes ☐ No
18. Do you operate any advanced CT imaging equipment? ☐ Yes ☐ No
    If yes, please complete the following:
    a. Do you own the radiology equipment? ☐ Yes ☐ No
    b. Is the equipment used on patients other than your own? ☐ Yes ☐ No
    c. Are the results read by a radiologist? ☐ Yes ☐ No

## V. Claims & Experience Information

Please explain all yes answers to Questions 1-4 on page 4 of the application

1. Have you ever been charged or convicted of a criminal offense? ☐ Yes ☐ No
2. Have you ever been a participant in a drug or alcohol dependency program? ☐ Yes ☐ No
3. Have you experienced or become aware of any illness or physical disability that impairs or could impair your ability to practice dentistry? ☐ Yes ☐ No
   **If yes, please include documentation from your treating physician stating your condition, prognosis and any limitations on your ability to practice dentistry**
4. Have you ever been investigated for/or charged with fraud, including, Medicare/Medicaid fraud? ☐ Yes ☐ No
5. Have you ever been the subject of a malpractice claim or suit? If yes, how many? _____ ☐ Yes ☐ No

   **If yes, please complete a Claim Supplement form for each claim and submit a loss run from all carriers that provided coverage during the past ten year period**

6. Are you aware of any incidents that occurred that might give rise to a malpractice claim or suit? ☐ Yes ☐ No
   **If yes, please complete a Claim Supplement form for each incident**
7. Have you ever been involved in a situation involving the death of a patient? ☐ Yes ☐ No
   **If yes, please complete a Claim Supplement form for each situation**

## VI. Entity Affiliations (Entity Includes Any Dental Corporation, Partnership, Group Or Other Legal Entity)

1. Practice Affiliation: ☐ Owner ☐ Employee ☐ Independent Contractor
2. Please provide the number of Allied Health Personnel working in your office: Dental Assistants _____
   Dental Hygienists _____ Advanced Dental Hygienists _____ Other (_____) _____
3. Do you practice on behalf of a dental corporation, partnership, group or entity? ☐ Yes ☐ No
   If yes, please complete the following:
   a. What is the legal name of the entity? _____
   _____
   b. List any Doing Business As names (DBA's): _____
   _____

   **If ownership interest exists in the entity(s) named above, please complete question #4**

4. Please indicate which coverage is desired for your entity by initialing your selection:

   _____ Initial Here — Add my sole shareholder entity as an Additional Insured on my individual policy to share in my limits of liability with no additional premium charge.

   _____ Initial Here — Issue a separate entity policy with a separate set of limits of liability for an additional premium charge. I have completed the Entity Supplement and have attached it to this application.

   _____ Initial Here — I do not wish to obtain coverage for my entity at this time.

**Please use this page to provide any additional information requested above in the application. Please reference the question for which you are providing additional information. If additional space is needed, please attach a separate page.**

## Warning

Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud. Such person may be subject to denial of insurance benefits, civil penalties and/or criminal penalties.

In CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In KY: Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects a person to criminal and civil penalties.

In VA & ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

In FL: 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.

## Acknowledgement

I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and I have not omitted or withheld any fact or circumstance, which would be relied upon in the determination by Fortress Insurance Company (“Company”) in granting liability insurance. I understand that this application, and any documents provided are made a part of the policy that is issued. Further, I agree to abide by any recommendations of the Company with regard to loss prevention issues.

I authorize any state board of examiners or licensers, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to the Company or its assigns. I authorize the use of a copy of this Acknowledgement in lieu of its original.

I understand the execution of this application is not a guarantee of coverage and that the Company may, in its sole and absolute discretion, accept or reject this application for professional liability insurance coverage. This acknowledgement shall be governed and interpreted in accordance with the laws of the state in which this policy is issued.

Signature _____ Date _____

## Privacy Notice

Fortress Insurance Company considers all transactions with us private and confidential. The United States Department of Health and Human Services has issued an opinion letter indicating that the obtaining and maintaining of professional liability insurance is a part of health care operations and therefore would not require a business associate agreement nor any releases for disclosure of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).

We may use and disclose Protected Health Information in our possession for proper management, administration and/or to fulfill any present or future legal responsibilities provided that the disclosures are required by law; or that such uses are permitted under state and federal confidentiality laws; or that we have received assurances of the confidential handling of such Protected Health Information.

We require all subcontractors and agents that perform the services we are obligated to perform under this application to adhere to the same restrictions and conditions on the use and disclosure of Protected Health Information that apply to you and to us for any Protected Health Information that they receive, use or have access to.

Should this application be declined or withdrawn, the protections of this statement will remain in force, and we shall make no further uses and disclosures of your Protected Health Information, except for the proper management and administration of our business or as required by law.

## Prior Acts Certification

If you ask us to provide coverage for "Prior Acts" ("Nose Coverage") for your professional liability exposure, you must inform all prior carriers of any claims, incidents or circumstances that might lead to a claim being made against you. Please provide written documentation that verifies you have informed all prior carriers of such incidents, etc. It is not the intent of the Fortress Policy to cover such known patient injuries. Your prior carriers should cover incidents/claims arising out of these injuries. Please read and sign the following statement.

I certify that I am not aware of any incidents or circumstances, which I might expect to result in a claim, except those listed in this application for insurance. I understand that my Fortress Policy will not provide coverage for such incidents of which I am aware regardless of whether I have reported them to my prior insurance carriers.

Signature _____ Date _____

Agent Signature: _____

# ENTITY SUPPLEMENT (ENTITY INCLUDES ANY DENTAL CORPORATION, PARTNERSHIP, GROUP OR OTHER LEGAL ENTITY)

FORTRESS

THIS FORM IS REQUIRED TO BE COMPLETED FOR A SEPARATE ENTITY POLICY TO BE ISSUED AS REQUESTED ON PAGE 4 OF THE INDIVIDUAL APPLICATION, PER SECTION VI ENTITY AFFILIATIONS. **PLEASE SUBMIT A COPY OF THE ENTITY'S ARTICLES OF INCORPORATION OR ARTICLES OF ORGANIZATION.**

## I. ENTITY INFORMATION

1. Legal Name of Entity: _____
2. Mailing Address: _____
   City: _____ County: _____ State: _____ Zip: _____
3. Billing Address (if different than mailing address): _____
   City: _____ County: _____ State: _____ Zip: _____
4. Name of Owner(s)/Partner(s): _____
   _____
5. Name of Practice Administrator: _____
6. Entity Website: _____
7. List any Doing Business As names (DBA's): _____
   _____

## II. COVERAGE INFORMATION (NOTE: The coverage type and limits of the entity policy must be the same as the underlying individual coverage)

1. Requested Effective Date: _____
2. Coverage Type: ☐ Claims-Made ☐ Occurrence
3. If Claims-Made coverage is requested, please indicate if prior acts coverage is desired: ☐ Yes ☐ No
   If yes, please indicate your Retroactive Date: _____
   **Please submit your current professional liability declarations page**
4. Limits Requested (each person/aggregate limit): ☐ $250,000/$750,000
5. Please list all of your previous entity professional liability insurers for the past 10 years:

| Insurance Company | Coverage Type | From (Month/Year) | To (Month/Year) |
|---|---|---|---|
| _____ | ☐ Claims-Made ☐ Occurrence | _____ | _____ |
| _____ | ☐ Claims-Made ☐ Occurrence | _____ | _____ |
| _____ | ☐ Claims-Made ☐ Occurrence | _____ | _____ |

## III. OFFICE LOCATIONS

List all current practice locations in this section. Please assign a Facility Code to each location to identify the type of office location. **Please use the space provided on page 3 of the supplement for additional locations.**

Facility Codes:
01 – Dental Office
02 – Hospital
03 – Nursing Home
04 – Government Office
05 – Surgi-Center
06 – HMO, IPA, PPO
07 – Dental Laboratory
08 – Mobile Dental Unit
09 – Other _____

1. Facility Code: _____
   Address: _____
   City: _____ County: _____ State: _____ Zip: _____
   Phone Number: _____ Fax Number: _____

2. Facility Code: _____
   Address: _____
   City: _____County: _____ State:_____ Zip:_____
   Phone Number: _____ Fax Number: _____
3. Facility Code: _____
   Address: _____
   City: _____County: _____ State:_____ Zip:_____
   Phone Number: _____ Fax Number: _____

## IV. Entity Census

1. Please provide census information for each dentist affiliated with your entity. Please assign an Affiliation Code for each individual.

**Please submit a certificate of insurance for each dental affiliate**

**If the entity has 10 or more dentist affiliates, please complete the Entity Structure Form**

Affiliation Codes: 01 – Owner/Partner/Shareholder 02 – Employee 03 – Independent Contractor

| | Name / Affiliation Code | Specialty | Insurance Carrier | Is this the dentists primary practice location? (Y/N) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

2. Please provide the number of Allied Health Personnel working in your office: Dental Assistants _____
   Dental Hygienists _____ Advanced Dental Hygienists _____ Other (_____) _____
3. Do any of the Allied Health Personnel perform expanded functions? ☐ Yes ☐ No
   **If yes, please describe on page 3 of the application**

## V. Claims & Experience Information

1. Has the entity ever filed for bankruptcy? ☐ Yes ☐ No
   **If yes, please explain on page 3 of the supplement**
2. Has the entity's professional liability coverage ever been declined, cancelled or non-renewed? ☐ Yes ☐ No
   **If yes, please submit copy of any notice**
3. Does the entity contract with any governmental facility such as prisons, VA Hospitals, etc? ☐ Yes ☐ No
   **If yes, please provide a copy of any contract between the entity and the facility**
4. Does this entity own or operate any other business? ☐ Yes ☐ No
   **If yes, please explain a description of the business and the relation to the entity applying for Coverage on page 3 of the supplement**
5. Has a malpractice claim ever been filed against the entity? If yes, how many? _____ ☐ Yes ☐ No
   **If yes, please complete a Claim Supplement form for each claim and submit a loss run**
6. Has any dental affiliate of the entity ever been named in a malpractice claim or suit? ☐ Yes ☐ No
   **If yes, please complete a Claim Supplement form for each claim**

7. Are you aware of any incidents that occurred that might give rise to a malpractice claim or suit? ☐ Yes ☐ No
   **If yes, please complete a Claim Supplement form for each incident**
8. Has the entity ever been involved in a situation involving the death of a patient? ☐ Yes ☐ No
   **If yes, please complete a Claim Supplement form for each incident**

**Please use this space to provide any additional information requested on the supplement. Please reference the question number for which you are providing additional information. If additional space is needed, please attach a separate page.**

## Warning

Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud. Such person may be subject to denial of insurance benefits, civil penalties and/or criminal penalties.

In CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In KY: Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects a person to criminal and civil penalties.

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In FL: 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.

## Acknowledgement

I, the undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and I have not omitted or withheld any fact or circumstance, which would be relied upon in the determination by Fortress Insurance Company (“Company”) in granting liability insurance. I understand that this application, and any documents provided are made a part of the policy that is issued. Further, I agree to abide by any recommendations of the Company with regard to loss prevention issues.

I authorize any state board of examiners or licensers, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to the Company or its assigns. I authorize the use of a copy of this Acknowledgement in lieu of its original.

I understand the execution of this application is not a guarantee of coverage and that the Company may, in its sole and absolute discretion, accept or reject this application for professional liability insurance coverage. This acknowledgement shall be governed and interpreted in accordance with the laws of the state in which this policy is issued.

Signature _____ Date _____

## Privacy Notice

Fortress Insurance Company considers all transactions with us private and confidential. The United States Department of Health and Human Services has issued an opinion letter indicating that the obtaining and maintaining of professional liability insurance is a part of health care operations and therefore would not require a business associate agreement nor any releases for disclosure of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).

We may use and disclose Protected Health Information in our possession for proper management, administration and/or to fulfill any present or future legal responsibilities provided that the disclosures are required by law; or that such uses are permitted under state and federal confidentiality laws; or that we have received assurances of the confidential handling of such Protected Health Information.

We require all subcontractors and agents that perform the services we are obligated to perform under this application to adhere to the same restrictions and conditions on the use and disclosure of Protected Health Information that apply to you and to us for any Protected Health Information that they receive, use or have access to.

Should this application be declined or withdrawn, the protections of this statement will remain in force, and we shall make no further uses and disclosures of your Protected Health Information, except for the proper management and administration of our business or as required by law.

## Prior Acts Certification

If you ask us to provide coverage for "Prior Acts" ("Nose Coverage") for your professional liability exposure, you must inform all prior carriers of any claims, incidents or circumstances that might lead to a claim being made against you. Please provide written documentation that verifies you have informed all prior carriers of such incidents, etc. It is not the intent of the Fortress Policy to cover such known patient injuries. Your prior carriers should cover incidents/claims arising out of these injuries. Please read and sign the following statement.

**I certify that I am not aware of any incidents or circumstances, which I might expect to result in a claim, except those listed in this application for insurance. I understand that my Fortress Policy will not provide coverage for such incidents of which I am aware regardless of whether I have reported them to my prior insurance carriers.**

Signature _____ Date _____

Agent Signature: _____

# Entity Structure Form

FORTRESS

TO BE COMPLETED BY ALL GROUPS OF 10 OR MORE DENTAL AFFILIATES

## I. General Information

1. Legal Name of Entity: _____
2. Provide the amount of premiums paid for each of the last three years:
   Year: _____ Premium $ _____
   Year: _____ Premium $ _____
   Year: _____ Premium $ _____
3. Total number of employed dentists for each of the last three years:
   Year: _____ # of Employed Dentists _____
   Year: _____ # of Employed Dentists _____
   Year: _____ # of Employed Dentists _____
4. Total revenues for each of the last 3 years:
   Year: _____ Revenue $ _____
   Year: _____ Revenue $ _____
   Year: _____ Revenue $ _____
5. List any market segment that represents more than 25% of your annual revenue:
   Market Segment: _____ % of Revenue: _____
   Market Segment: _____ % of Revenue: _____
   Market Segment: _____ % of Revenue: _____

## II. Entity Operations

Please submit a detailed narrative regarding each of the items listed below:

- Describe your referral policy
- Describe your employment qualifications and credentialing process for employed dentists
- Describe your compensation policy, including any incentives
- Describe your quality control procedures
- Describe your risk management procedures, including how incidents or patient complaints are handled
- Describe your anesthesia/sedation procedures, including emergency procedures
- Describe your collection and write-off procedures. Please include the amount written off for each of the last 3 years

## III. Additional Documentation

Please submit the following documents:

- Sample of an employment contract
- Copies of all Medical History and Informed Consent Forms

Agent Signature: _____

# Claim Supplement Form

FORTRESS

PLEASE COMPLETE A FORM FOR EACH CLAIM/INCIDENT THAT YOU HAVE BEEN INVOLVED IN. IF ADDITIONAL FORMS ARE NEEDED, PLEASE MAKE A PHOTOCOPY PRIOR TO COMPLETION.

**PLEASE PROVIDE A LOSS RUN FROM ALL CARRIERS PROVIDING COVERAGE IN THE PAST 10 YEARS**

## I. General Information

1. ☐ Claim ☐ Incident
2. Patient name: _____
3. Date claim/incident occurred: _____
4. Professional liability insurance company involved: _____
5. Date claim/incident was reported to insurance company named above: _____

## II. Description Of Event

1. Treatment Involved: _____
   _____
   _____
2. Allegations: _____
   _____
   _____
   _____
3. Outcome of Treatment: _____
   _____
   _____
   _____
   _____
   _____
4. Name any other dentists or healthcare professionals involved in the treatment of this patient: _____
   _____
   _____

## III. Status

1. What is the current status of the claim/incident?
   ☐ Open ☐ Closed on _____ /_____ /_____
2. If closed, please note the method of closing:
   ☐ Claim Settled ☐ Claim Dismissed/Closed with Defense Verdict ☐ Claim Closed with Judgment
3. If closed, please note the amount paid:
   Total Indemnity Paid: $_____ Total Expenses Paid: $_____

Agent Signature: _____