



NEWLY GRADUATED DENTAL STUDENT PROFESSIONAL LIABILITY APPLICATION

- All questions must be answered. If you don't have enough space, please attach a separate sheet of paper.
- Coverage will be effective only upon receipt and approval by Professional Solutions Insurance Company (Professional Solutions).

Section 1 — GENERAL INFORMATION

1. Name: _____
First Middle Initial Last Designation
2. Date of Birth: ____/____/____ Gender: Male Female
3. License Number: _____ State of License: _____
4. Mailing Address: _____
Street City State Zip Code
5. Practice Name and Address: _____
Practice Address
- _____ Street City County State Zip Code
6. Daytime Phone: (____) _____ Evening (____) _____ Fax Number (____) _____
7. Email Address: _____ Website Address: _____
Your email address will never be sold. It will be used for sending you important notices.

Section 2 — EDUCATION/TRAINING AND PROFESSIONAL EXPERIENCE

8. Education / Dental School Attended: _____ / _____
Month/Year of Graduation
9. Did you complete a residency? YES NO
10. Specialty: _____ Month/Year of Completion: _____ / _____
11. If you are a graduate of a dental school outside the United States, are you certified by your practicing State Board of Dental Examiners? YES NO
12. Have you ever practiced before? YES NO
(If "Yes", a full Professional Solutions application is required, prior to coverage approval)

Section 3 — COVERAGE INFORMATION

13. Date you want your coverage to become effective: ____/____/____
Month Day Year
14. Type of Policy Requested: Claims-Made Occurrence
15. Limits desired:
 \$2,000,000/\$4,000,000 \$500,000/\$1,000,000 \$200,000/\$600,000
 \$1,100,000/\$3,000,000 \$250,000/\$750,000 \$100,000/\$300,000
16. Please indicate your area of practice:
 General Dentistry Pedodontics Oral/Maxillofacial Radiology
 Endodontics Periodontics Oral Pathology
 Forensic Dentistry Prosthodontics Orthodontics
 Pediatric Dentistry Public Health Sports Medicine Other: _____
17. Business Structure
 Sole Proprietor*
 Partnership*
 Employee
 Independent Contractor
 Other: _____

* If you are an owner/partner of a professional entity and request coverage for it, please complete a Professional Solutions Insurance Company Entity Coverage application.

Section 3 — COVERAGE INFORMATION...continued

18. If you perform any of the following, you will need to complete a supplementary application prior to coverage approval.

- Administration of General Anesthesia to induce unconscious sedation
- Apicoectomies/Periradicular Services
- Bone Grafts
- Implant Surgery
- Implant Restoration
- Manufacture maxillofacial prosthetics
- Sinus Augmentation
- Sleep Apnea Therapy (invasive)
- Surgical Excision of intra-osseous lesions
- Surgical Extractions of Impacted teeth
- TMJ Treatments Phase II
- Weight Loss Therapy

19. Do you discuss/document informed consent? YES NO

20. Do you have a transfer plan for emergencies? YES NO

21. Do you operate a mobile dental practice? YES NO

If "yes," please provide the following on a separate sheet:

- What types of services will you provide?
- What equipment and staff do you bring with you?
- What emergency procedures are in place?
- Geographic area and patient demographics
- Do you obtain a parent/guardian signature for treatment of minors?

22. Please list any other dental techniques that will help Professional Solutions better understand any special circumstances concerning your practice: _____

Section 4 — BILLING INFORMATION

Choose your billing frequency: Annually Semi-Annual Quarterly

Section 5 — SIGNATURE REQUIRED

Insurance coverage becomes effective upon approval of the application and issuance of the policy. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT. Acceptance of the premium does not constitute approval of the application.

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection.

By signing this application the applicant authorizes the company to conduct any and all necessary background investigations in support of this application of insurance. When you provide a check, you authorize us to use information from your check to make a one-time electronic funds transfer from your account. When we use your check to make an electronic funds transfer, funds may be withdrawn from your account on the same day we receive your check and you will not receive your check back from your financial institution.

X _____ **X** _____
SIGNATURE DATE

For residents of all states except Maryland, New York, New Jersey, Virginia and Washington: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Maryland residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

New Jersey residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Virginia and Washington residents: 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.

Malpractice insurance is underwritten by Professional Solutions Insurance Company and administered by Professional Solutions Insurance Services, Inc., a licensed insurance agency.

X _____ **X** _____
AGENT SIGNATURE DATE