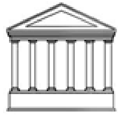
Commonwealth Underwriters Ltd.

P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
Fax: 888-359-6994
www.commund.com

APPLICATION FOR DENTAL COSMETIC PROFESSIONAL LIABILITY INSURANCE

Notice: The policy for which application is made applies only to "Claims" first made during the "Policy Period". The limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible, unless the policy is amended by endorsement. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: ____________________
   (ii) Professional Degree: ____________________
   (b) Principal practice address: ____________________
   (Street) (County)
   ____
   (City) (State) (Zip)
   (c) Secondary practice locations: ____________________
   ____
   ____
   (d) (i) Phone: ____________________ (ii) Fax: ____________________
   (iii) E-Mail Address: ____________________ (iv) Website Address: ____________________
   (e) (i) Date of Birth (MM/DD/YYYY): ____________________ (ii) Place of Birth: ____________________

2. Are you a U.S. citizen? .... [ ] Yes [ ] No
   If No, what is your status in the U.S. and current citizenship? ____________________

3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
   [ ] professional corporation* [ ] professional association*
   [ ] limited liability company* [ ] partnership*
   [ ] employee of ____________________ [ ] independent contractor of ____________________
   [ ] other ____________________
   * Specify name of entity: ____________________
   (b) Do you want coverage for the entity named Item 3(a) above? .... [ ] Yes [ ] No
   (c) Attach a copy of your letterhead.
   (d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all others practicing under the entity name in Item 3(a)above.
   ____
   ____

4. Do you practice with any dentist not named in Item 3.(d) above? .... [ ] Yes [ ] No
   If Yes, provide the name of each dentist and the practice relationship. ____________________
   ____

5. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

6. Federal DEA License No. and status: ____________________

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

If Yes,
(a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .... [ ] Yes [ ] No
(b) Provide the name and title of the Applicant's Privacy Officer.______________________________

Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

1. (a) Provide your dental specialty: ______________________________
   (b) Do you limit your practice to the specialty stated in item (a) above? .... [ ] Yes [ ] No
   If No, provide details. ______________________________

2. Are you American dental board certified in any specialty? .... [ ] Yes [ ] No
   If Yes, provide the following: Board(s) in which you are certified:______________________________
   Date of certification:______________________ Any recertification date(s):______________________
   If No, do you plan on taking a Board examination? .... [ ] Yes [ ] No

3. Provide the following information:

	Name of Institution	City	State	Date Completed
Dental School				
Internship – Specialty:__________				
Residency – Specialty:__________				
Fellowship – Specialty:__________				
Other:__________				

4. If you graduated from a foreign dental school, provide the date began your practice in the United States:____________

5. Have you practiced continually for the last ten (10) years, except for any military leave? .... [ ] Yes [ ] No
   If No. explain.______________________________

III. PROFESSIONAL SERVICES

1. List all manufactured equipment and drugs used in the Applicant's practice and the purpose for which each is used. Attach separate sheet if necessary.

Equipment/Drug	**Purpose**	**Used only as approved by the FDA? (Yes or No)**	**If No, describe off-label usage.**

2. Does the Applicant take before and after pictures of every patient? .... [ ] Yes [ ] No
   If No, explain. ______________________________
   ____

3. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment? .... [ ] Yes [ ] No
   If No, explain. ______________________________

IV. PROCEDURES

1. Botox Injections
   Does the Applicant perform Botox Injections? .... [ ] Yes [ ] No
   If Yes, complete the following:
   (a) Total number of Botox Injections: .... (i) Last 12 months: ______ (ii) Next 12 months: ______
   (b) Who performs Botox Injections? ....
   ____ Physician ____ Physician's Assistant ____ Nurse
   ____ Dentist ____ Nurse Practitioner ____ Other-describe: ______________

(c) Have all staff performing Botox Injections:
   (i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .... [ ] Yes [ ] No
   (ii) Performed a minimum of ten procedures on live patients? .... [ ] Yes [ ] No

2. Chemical Peels

Does the Applicant perform Chemical Peels? .... [ ] Yes [ ] No
If Yes, complete the following:

(a) Total number of Chemical Peels with solution strength <30%:.. (i) Last 12 months: _____ (ii) Next 12 months: _____
   (i) Who performs Chemical Peels with solution strength <30%:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

   (ii) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specifically for this procedure including anatomy, physiology, skin typing, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .... [ ] Yes [ ] No

(b) Total number of Chemical Peels with solution strength >30%:.. (i) Last 12 months: _____ (ii) Next 12 months: _____
   (i) Who performs Chemical Peels with solution strength >30%:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

3. Dermal Fillers

Does the Applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)? .... [ ] Yes [ ] No
If Yes, complete the following:

(a) Total number of Dermal Fillers: .... (i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs Dermal Fillers?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Have all staff performing Dermal Fillers:
   (i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .... [ ] Yes [ ] No
   (ii) Performed a minimum of five procedures on live patients? .... [ ] Yes [ ] No
(d) Does the Applicant:
   (i) Use only dermal fillers approved by the FDA? .... [ ] Yes [ ] No
   If No, explain:____
   (ii) Disclose off-label use to all patients receiving such treatment on the patient consent form? .... [ ] Yes [ ] No

4. Laser Skin Treatments

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, and Laser Vein Treatments? .... [ ] Yes [ ] No
If Yes, complete the following:

(a) Total number of Laser Skin Treatments: .... (i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs Laser Skin Treatments Injections?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Does the Applicant comply with the following standards of practice:
   (i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. .... [ ] Yes [ ] No
   (ii) Prior to the initiation of any patient care activity the individual has read and sign the clinic's policies and procedures regarding the safe use of lasers. .... [ ] Yes [ ] No
   (iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) .... [ ] Yes [ ] No
   (iv) A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented. .... [ ] Yes [ ] No

(v) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician. .... [ ] Yes [ ] No

(d) Does the Applicant comply with the following standards of practice for non-dentist use of laser related technology:

(i) Any dentist who delegates a procedure to a non-dentist must be qualified to do these laser procedures themselves by virtue of having received appropriate training in physics, safety, surgical techniques, pre and post operative care, and be able to handle the resultant emergencies or sequela. .... [ ] Yes [ ] No

(ii) Any licensed medical professional employed by a dentist to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice.......... [ ] Yes [ ] No

(iii) A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site dentist supervision and following written procedures.... [ ] Yes [ ] No

(iv) The supervising dentist is available on-site to respond to any untoward event that may occur. Ultimate responsibility lies with the supervising physician. .... [ ] Yes [ ] No

5. Massage Therapy/Cellulite Treatments

Does the Applicant perform Massage Therapy/Cellulite Treatments? .... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Massage Therapy / Cellulite Treatments: ..... (i) Last 12 months: ______ (ii) Next 12 months: ______

(b) Who performs Massage Therapy / Cellulite Treatments?

___ Physician ___ Physician's Assistant ___ Nurse

___ Massage Therapist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements? .... [ ] Yes [ ] No

If No, explain. ____

6. Mesotherapy and/or Lipodissolve

Does the Applicant perform Mesotherapy and/or Lipodissolve? .... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Mesotherapy/Lipodissolve Treatments: .... (i) Last 12 months: ______ (ii) Next 12 months: ______

(b) Who performs Mesotherapy/Lipodissolve at this clinic?

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Are all staff performing Mesotherapy and/or Lipodissolve licensed dentists with a minimum of eight hours training to perform Mesotherapy and/or Lipodissolve including anatomy, physiology, contraindications, potential complications, and performance of at least one procedure on each part of the anatomy for which coverage is desired?.......... [ ] Yes [ ] No

7. Microdermabrasions

Does the Applicant perform Microdermabrasions? .... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Microdermabrasions: .... (i) Last 12 months: ______ (ii) Next 12 months: ______

(b) Who performs Microdermabrasion:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Have all staff performing Microdermabrasion treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? .... [ ] Yes [ ] No

If No, explain: ____

8. Micropigmentation / Permanent Makeup

Does Applicant perform Micropigmentation / Permanent Makeup? .... [ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Permanent Makeup / Micropigmentations: ... (i) Last 12 months: ______ (ii) Next 12 months: ______

(b) Who performs Permanent Makeup / Micropigmentations:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Have all staff performing Permanent Makeup / Micropigmentation treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? .... [ ] Yes [ ] No
If No, explain: ______________________________

9. Sclerotherapy Injections

Does the Applicant perform Sclerotherapy Injections? .... [ ] Yes [ ] No
If Yes, complete the following:
(a) Total number of Sclerotherapy Injections: .... (i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs Sclerotherapy Injections?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Are all staff performing Sclerotherapy Injections dentists who have received a minimum of eight hours training specific for this procedure, including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of a minimum of one procedure on a live patient? .... [ ] Yes [ ] No

10. Tattoo Removals

Does the Applicant perform Tattoo Removals? .... [ ] Yes [ ] No
If Yes, complete the following:
(a) Total number of Tattoo Removals: .... (i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs Tattoo Removal:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: ________________

(c) Are all staff performing Tattoo Removal licensed dentists who comply with the following standards of practice:
(i) Dentists are trained appropriately in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. .... [ ] Yes [ ] No
(ii) Prior to the initiation of any patient care activity the dentist has read and signed the clinic's policies and procedures regarding the safe use of lasers. .... [ ] Yes [ ] No
(iii) Continuing education of all dentists is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) .... [ ] Yes [ ] No

11. Surgical or Minor Surgical / Invasive Procedures

Does the Applicant perform surgical or minor surgical/invasive procedures? .... [ ] Yes [ ] No
If Yes, complete the following:
(a) Total number of surgical procedures: .... (i) Last 12 months: _____ (ii) Next 12 months: _____
(b) Who performs surgical and/or minor surgical/invasive procedures?

____

(c) Provide a complete list of all surgical and minor surgical/invasive procedures being performed: Attach a separate sheet if necessary.

____

V. CLAIMS AND HISTORY

1. List your prior Professional Liability Insurance for each of the last (5) years, including the current year:

(a)

	Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
(1)						
(2)						
(3)						
(4)						
(5)						

(b) Does the policy for the current year allow the reporting of any incidents or circumstances that are likely to result in a claim? .... [ ] Yes [ ] No
(c) Do any of the above policies provide coverage for any:
(i) procedures not describes in this application and in which you no longer perform? .... [ ] Yes [ ] No
(ii) practice(s) not described in this application? .... [ ] Yes [ ] No

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? .... [ ] Yes [ ] No
If Yes, how many? __________Complete a copy of our Supplemental Claim form for each one.

3. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer?...................................... [ ] Yes [ ] No
If Yes, how many? __________Complete a copy of our Supplemental Claim form for each one.

4. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? .... [ ] Yes [ ] No
If Yes, how many? _________ Complete a copy of our Supplemental Claim form for each one.

5. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges?... [ ] Yes [ ] No

6. Has your license to practice dentistry or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? .... [ ] Yes [ ] No

7. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? .... [ ] Yes [ ] No

8. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? .... [ ] Yes [ ] No

9. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? .... [ ] Yes [ ] No

10. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? .... [ ] Yes [ ] No

VI. ADDITIONAL INFORMATION

As part of this Application, attached the following:

1. A copy of training certificate for each procedure in Section IV., Procedures, that the Applicant performs.

2. A copy of consent formed for each procedure in Section IV., Procedures, that the Applicant performs.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a Claim or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any Claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

(i) the policy for which this application is made applies only to “Claims” first made during the “Policy Period”;

(ii) unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by “Claim Expenses” and, in such event, the Company will not be liable for “Claim Expenses” or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

(iii) unless amended by endorsement, “Claim Expenses” shall be applied against the “Deductible”.

WARRANTY

I warrant to the Company, 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 and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

______________________________	______________________________
Name of Applicant	Title
______________________________	______________________________
Signature of Applicant	Date

Notice to Applicants: 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 the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

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

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: