



**DENTAL GROUP QUICK QUOTE**

**Please use this quick quote form to submit your current information to PMIS:**

\_\_\_\_\_ **Please send me an application or further instructions.**

\_\_\_\_\_ **Please have a representative contact me at \_\_\_\_\_.**

**CONTACT INFORMATION:**

**First Name:**

**Last Name:**

**Street Address:**

**City:**

**State:**

**Zip:**

**Email address:**

**Phone:**

**Fax:**

**Name of Risk to be Insured:**

**Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Fax:**

**Full describe practice:**

Is this a Dental Group? \_\_\_\_\_ Any other names to be added? DBA's? \_\_\_\_\_

**LIMITS OF LIABILITY REQUIRED:**

- \_\_\_\_\_ \$200,000/600,000
- \_\_\_\_\_ \$250,000/750,000
- \_\_\_\_\_ \$500,000/1,500,000
- \_\_\_\_\_ \$1,000,000/\$3,000,000
- \_\_\_\_\_ OTHER: \_\_\_\_\_

**Effective requested:**

**Retroactive date:**

(you may find your retroactive date on the face sheet of your current policy; it is shown near your premium, address, name, limits or specialty code and reflects the first date you purchased claims made coverage).

If no retroactive date, do you have an occurrence policy? \_\_\_\_\_

**TELL US ABOUT YOUR GROUP:**

Addresses of all the places you practice:

Office phone:

Office fax:

Years in practice: \_\_\_\_\_

Weekly patient load: \_\_\_\_\_

How many hours a week does the group practice? \_\_\_\_\_

How many employed dentists? \_\_\_\_\_ How many independent contractor dentists? \_\_\_\_\_ How many ancillary personnel? \_\_\_\_\_

Is everyone in the group currently licensed to practice in your state(s)? \_\_\_\_\_

Can you provide CV's on your dental staff if necessary? \_\_\_\_\_

Is everyone in the group currently acquiring CDE's as required by State Boards of society memberships? \_\_\_\_\_

Has anyone or all of the group taken a professional liability risk management course in the last three years? \_\_\_\_\_ If yes, please explain:

List below any Dental Professional Societies to which members of the group belong:

**CHARACTER OF PRACTICE:**

Please provide the approximate percentage of patients treated by your group in the following areas:

- \_\_\_\_ % General Dentistry
- \_\_\_\_ % Dental Public Health
- \_\_\_\_ % Pediatric Dentistry
- \_\_\_\_ % Periodontics
- \_\_\_\_ % Gen'l Dentistry limited to TMJ, Implants
- \_\_\_\_ % Oral Pathology
- \_\_\_\_ % Orthodontics
- \_\_\_\_ % Endodontics
- \_\_\_\_ % Prosthodontics

**Specialized Areas:\*\***

- \_\_\_\_ % Oral surgery
- \_\_\_\_ % Implant surgery
- \_\_\_\_ % TMJ Surgery
- \_\_\_\_ % Full Mouth Reconstruction
- \_\_\_\_ % Treatment in an accredited hospital or surgicenter

**\*\*Please provide a description of services performed and training for same on a separate sheet.**

**PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA:**

Is your group practice limited to the use of local anesthesia and/or oral medication, including Nitrous Oxide euphoria? \_\_\_\_\_

\*Are you treating patients who are under conscious sedation? (For purposes of this application, the use of Nitrous Oxide solely as an analgesic is not considered conscious sedation.) \_\_\_\_\_

\*Are you treating patient who are under general anesthesia? \_\_\_\_\_

Are you equipped and trained to use the following emergency procedures?

Positive pressure endotracheal respiratory assistance? \_\_\_\_\_

Intravenous emergency medications? \_\_\_\_\_

External heart massage? \_\_\_\_\_

Other, please specify:

**\*If you answered yes to starred questions, please complete the following:**

**Type of anesthesia/analgesic used while treating patients under General Anesthesia:**

**Inhalation: (type)** \_\_\_\_\_

\_\_\_\_ Nitrous Oxide

\_\_\_\_ Other:

**Intravenous:** \_\_\_\_\_

**Intramuscular (inc. submuscosal):** \_\_\_\_\_

**Oral:** \_\_\_\_\_

**Combination:** \_\_\_\_\_

Where are the General Anesthesia procedures performed?

\_\_\_\_\_ % Dental Office

\_\_\_\_\_ % Hospital

\_\_\_\_\_ % number of procedures per month

Please indicate the number of years you have been using Conscious Sedation: \_\_\_\_\_  
and/or General Anesthesia \_\_\_\_\_ in your office \_\_\_\_\_.

Please indicate if you have had the following training, and if so, the date and period of time spent in training:

Hospital training in the use of General Anesthesia: \_\_\_\_\_

University training in the use of General Anesthesia: \_\_\_\_\_

Hospital training in the use of Conscious Sedation: \_\_\_\_\_

University training in the use of Conscious Sedation: \_\_\_\_\_

Are you certified by, or a member of, any of the following organizations that require training in General Anesthesia? \_\_\_\_\_ AAOMS \_\_\_\_\_ ACOMS \_\_\_\_\_ Fellow, ADSA \_\_\_\_\_ Member, ADSA \_\_\_\_\_ other:

Are you or your staff ACLS certified?

Do you use the services of dental anesthesiologists, CRNA's (or similar)? \_\_\_\_\_

If yes, describe:

**PLEASE TELL US ABOUT YOUR PROFESSIONAL INSURANCE HISTORY:**

Please list your current insurance information *AND* attach a copy of the Declaration Page of your current policy (the face sheet that contains all of the information including premium, limits, effective dates, etc.)

Carrier: \_\_\_\_\_

Limits: \_\_\_\_\_

Retroactive date: \_\_\_\_\_

Have you had any professional liability insurance refused, cancelled or non-renewed in the past 5 years?

\_\_\_\_\_ If yes, state reason: \_\_\_\_\_

Has any claim or suit for alleged malpractice ever been filed against you? \_\_\_\_\_ If yes, attach a separate sheet explaining the dates, patient's description, allegations, carrier and out come including amounts paid-*or*- attach an insurance company-generated loss run to this form.

Are you currently aware of any situation that could lead to a malpractice suit against you? \_\_\_\_\_

If so, describe and advise if you have notified your current carrier of same: \_\_\_\_\_

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Please indicate which or the following, if any, have occurred in your practice:

Have you had a change in the status of your:

Dental License \_\_\_\_\_

Narcotics License \_\_\_\_\_

Hospital Priviledges \_\_\_\_\_

If yes, give details:

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Has any gov't agency, including a State Licensing Board, investigated you, suspended, revoked, or taken any action against you, your narcotics license or your license to practice dentistry? \_\_\_\_\_  
If yes, explain including providing a Board Transcript resolution:

Have you ever been convicted of any criminal charges? \_\_\_\_\_  
If yes, explain and provide details from investigating agency.

Have you had any personal health problems (including alcoholism, drug addiction, mental illness, or tested HIV positive for AIDS)? \_\_\_\_\_  
If yes, explain and provide a letter from treating physician with details.

I hereby declare that all statements and answers herein are full, complete and true, to the best of my knowledge and belief and that no material circumstance or information concerning the subject mater of the questions asked have been withheld or omitted.

I understand that the statements and answers herein will be relied upon by the Company receiving this application and are material in determining not only whether insurance coverage is issued or renewed, but also correct classification.

I authorize any professional societies, court search entities, prior to and present insurance carriers, business or medical associates, license boards, hospitals, governmental entities, corporations, partnerships, organizations, institutions or persons that may have any record of knowledge concerning any of the statements and answers made herein to release such information to the Company. I authorize the use of a copy of this authorization in place of the original.

I authorize the Company to provide any Risk Manager it may designate with any records and information concerning claims arising under any policy of insurance issued n connection with this application

I understand and accept that the policy applied for provides coverage on a claims made and reported basis for only those claims that are first made against the insured and reported to the Company while the policy is in force and that coverage ceases with the termination of the policy unless the options available in accordance with the terms of the policy are exercised.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

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