## 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

1. Requested Effective Date: 

2. Coverage Type:  
   
3. If Claims-Made coverage is requested, please indicate if prior acts coverage is desired:  
   
   If yes, please indicate your Retroactive Date: 
   
   Please submit your current professional liability declarations page

4. Limits Requested (each person/aggregate limit):  
   
   Agent Signature: __________________________   License Number: ____________________________
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
- 04 – Government Office
- 07 – Dental Laboratory
- 02 – Hospital
- 05 – Surgi-Center
- 08 – Mobile Dental Unit
- 03 – Nursing Home
- 06 – HMO, IPA, PPO
- 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

<table>
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<tr>
<th>Name / Affiliation Code</th>
<th>Specialty</th>
<th>Insurance Carrier</th>
<th>Is this the dentists primary practice location? (Y/N)</th>
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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.

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WARNING
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 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 ___________________________
ENTITY STRUCTURE FORM

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

WARNING

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.

Signature: ____________________________________________ Date: __________________________

Agent Signature: ______________________________________ License Number: __________________________

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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: $________________________

WARNING
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.

Signature__________________________________________ Date:________________________
Agent Signature: __________________________________________ License Number: __________