P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

RENEWAL - DENTIST AND ORAL SURGEON SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER NOT EARLIER THAN 45 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF COVERAGE.

ATTACH ADDITIONAL SHEETS AS NECESSARY.

ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

GENERAL INFORMATION

1)

Named Insured:	
Professional Designation:	Social Security Number:
US Citizen? Yes ☐ No ☐	Date of Birth:
Immigration status:	Entry date:
Federal DEA License #:	DEA License Status:
Phone Number:	Email Address:
Brokerage/Broker:	Agency/Agent:
Renewal? Yes ☐ No ☐	Policy Number:
Effective Date:	
Website:	

Please attach copies of the following:

a) Currently valued five year loss runs, including claim detail for all losses
b) A copy of all marketing materials, brochures, etc. if a website is not available
c) A copy of your business letterhead
d) A copy of all licenses and board certifications held by you
e) A copy of all reporting endorsements previously issued to you

2) Mailing Address: ______________________________
City: ____________________ State: ____________ Zip Code: ______________

3) Practice Address: ______________________________
City: ____________________ State: ____________ Zip Code: ______________

4) Are you a(n): ☐ Corporation ☐ Individual ☐ Partnership ☐ LLC
☐ Employed Dentist ☐ Contracted Dentist ☐ Other: ______________
a. If you are employed or contracted, by whom? ______________________________

5) Your practice is: ☐ Solo Practice ☐ Group Practice ☐ Other: ______________

6) What is the entity name of your practice? ______________________________
a. What is your ownership percentage? ______________________________ %
b. How many other dentists practice at this entity? ______________________________
c. Are you seeking coverage for this entity? If yes please attach articles of incorporation. Yes ☐ No ☐

7) Do you practice with any other dentists not included in 6) above? Yes ☐ No ☐
a. If yes, please list their name(s) and practice relationship: ______________________________
____

PRACTICE SPECIALTY RENEWAL INFORMATION

8) Have you had any changes to your specialization in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: ____
   ____

9) Have you had any changes to your contractual arrangements in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: ____
   ____

10) Have you had any changes to partnerships, corporations, or associations in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: ____
   ____

11) How many CE hours have you completed in the past 12 months? ____________________

12) Have you had any changes to your locations or practice in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: ____
   ____

13) In the past 12 months (please attach details for all "yes" answers):
   a. Have you become American Board Certified? Yes ☐ No ☐
   b. Has any State/Dental Board refused you a dental license? Yes ☐ No ☐
   c. Has any State/Dental Board restricted, suspended or revoked your dental license? Yes ☐ No ☐
   d. Has any State/Dental Board imposed a fine or any other obligation? Yes ☐ No ☐
   e. Has any State/Dental Board issued a letter of guidance or public reprimand? Yes ☐ No ☐
   f. Have you voluntarily surrendered a medical license? Yes ☐ No ☐
   g. Has any State/Dental Board placed you on probation or restricted your practice? Yes ☐ No ☐
   h. Is your dental license currently under investigation for any reason in any state? Yes ☐ No ☐
   i. Has your Narcotics/DEA license been surrendered/refused/suspended/revoked (voluntarily or otherwise)? Yes ☐ No ☐
   j. Has there been any professional conduct or fee complaint filed against you with any Specialty, National, State or County Dental Society, other Professional Association or any licensing or regulatory authority? Yes ☐ No ☐
   k. Has your membership in any dental association/society been refused, suspended, revoked, or voluntarily surrendered? Yes ☐ No ☐
   l. Have you been evaluated, treated, or recommended for treatment of alcohol, narcotics, or any other substance abuse, sexual addiction, or mental illness? Yes ☐ No ☐
   m. Have you been diagnosed with, or treated for, a chronic physical illness or disability? Yes ☐ No ☐
   n. Have you become aware of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice dentistry now or any time in the future? Yes ☐ No ☐

DENTAL PRACTICE AND PROCEDURE RENEWAL INFORMATION

14) Please complete the following table for procedures/treatments that you perform. Check and complete all that apply:

Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months	Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months
☐ Cosmetic Procedures – Non-Dental (complete 23) below)	%	%	☐ Cosmetic Dentistry (complete 22) below)	%	%
☐ Bone Grafting	%	%	☐ Endontics – Single Rooted	%	%

☐ Endontics – Multi Rooted	%	%	☐ Endontics – Sargenti Multi Rooted Canal Method	%	%
☐ General Dentistry – Root Canal	%	%	☐ General Dentistry – Oral Surgery	%	%
☐ General Dentistry – Extractions of Impacted Teeth	%	%	☐ General Dentistry – Simple Extractions Only	%	%
☐ Implants - Restoration	%	%	☐ Implants - Placement	%	%
☐ Microneurosurgical Procedures	%	%	☐ Oral Pathology	%	%
☐ Oral Radiology	%	%	☐ Orthodontics	%	%
☐ Orthognathic Procedures	%	%	☐ Pediatric Dentistry	%	%
☐ Periodontics	%	%	☐ Prosthodontics	%	%
☐ Prosthetics - Fixed	%	%	☐ Prosthetics - Removable	%	%
☐ Prosthetics – Sleep Apnea	%	%	☐ Prosthetics - Surgery	%	%
☐ Prosthetics - Therapy	%	%	☐ Surgery – Facial – Elective Cosmetic	%	%
☐ Surgery – Head and Neck	%	%	☐ Surgery – Oral/Maxillofacial	%	%
☐ Surgery – Outside Oral/Maxillofacial Region:______________	%	%	☐ TMJ – Non-Surgical	%	%
☐ TMJ – Surgical	%	%	☐ Uvulopalatoplasty	%	%
☐ Other: ___________	%	%	☐ Other: ___________	%	%
☐ Other: ___________	%	%	☐ Other: ___________	%	%
☐ Other: ___________	%	%	☐ NONE OF THE ABOVE	INITIAL TO CONFIRM: __________	

** Additional supplemental application required*

15) If you are performing cosmetic dental procedures, please indicate which you're performing. Check all that apply:

☐ Bonding ☐ Enamel Shaping ☐ Full Mouth Restoration
☐ Veneers ☐ Whitening with Lasers ☐ Other Laser Procedure: ___________
☐ Other Procedure: ______________ ☐ Other Procedure: ______________ ☐ Other Procedure: ________________

16) If you are performing cosmetic procedures, please indicate which you are performing. Check all that apply:

☐ Botox Injection ☐ Chemical Peels ☐ Chemobrasion
☐ Collagen Injection ☐ Dermabrasion ☐ Face Lift
☐ Laser Skin Resurfacing ☐ Lipodissolve ☐ Liposuction
☐ Microdermabrasion ☐ Reconstructive Surgery ☐ Rhinoplasty
☐ Silicone Injection ☐ Other Laser Procedure: _________ ☐ Other Procedure: ________________

a. Where are these performed?

☐ Office ☐ Hospital ☐ Other: _________________________

17) If you have performed any implant procedures in the last year, please check which and indicate how many. Check all that apply:

☐ Osseointegration only #____________ ☐ Endosteal - Ramus Frame #______________
☐ Endosteal - Other #____________ ☐ Subperiosteal #______________
☐ Transosseus #____________ ☐ Other: ____________________ #______________

a. Do you perform sinus lifts or other surgical procedure in conjunction with implant procedures? Yes ☐ No ☐

18) Have you had any changes to your procedures performed in the past 12 months? Yes ☐ No ☐

a. If yes, please describe: ____

____

19) Have you had any changes to your hospital or surgi-center privileges in the past 12 months? Yes ☐ No ☐

a. If yes, please describe: ____

____

20) What are your average weekly practice hours? ______________________________

21) How many weekly patient encounters do you have on average? ______________________

22) Approximate gross income from you practice: $______________________________

23) If you are performing any of the following surgical procedures/treatments, please indicate where they are performed:

Procedure	Location		
Acupuncture	☐ Office	☐ Hospital	☐ Other: ____________
Adenoidectomy	☐ Office	☐ Hospital	☐ Other: ____________
Assist in Surgery	☐ Office	☐ Hospital	☐ Other: ____________
Biopsies	☐ Office	☐ Hospital	☐ Other: ____________
Blepharoplasty	☐ Office	☐ Hospital	☐ Other: ____________
Cheek Implant	☐ Office	☐ Hospital	☐ Other: ____________
Chin Surgery	☐ Office	☐ Hospital	☐ Other: ____________
Cleft Lip/Palate Surgery	☐ Office	☐ Hospital	☐ Other: ____________
Clinical Trials	☐ Office	☐ Hospital	☐ Other: ____________
Closed Reduction Fractures	☐ Office	☐ Hospital	☐ Other: ____________
Complex Flaps and Grafts	☐ Office	☐ Hospital	☐ Other: ____________
Cryosurgery	☐ Office	☐ Hospital	☐ Other: ____________
Dental Alveolar Surgery	☐ Office	☐ Hospital	☐ Other: ____________
Extractions (Impacted)	☐ Office	☐ Hospital	☐ Other: ____________
Extractions (Non-Impacted)	☐ Office	☐ Hospital	☐ Other: ____________
Needle Biopsy	☐ Office	☐ Hospital	☐ Other: ____________
Nerve Grafts	☐ Office	☐ Hospital	☐ Other: ____________
Oral/Maxillofacial Surgery	☐ Office	☐ Hospital	☐ Other: ____________
Open Reduction of Fractures	☐ Office	☐ Hospital	☐ Other: ____________
Sargenti Root Canal Method	☐ Office	☐ Hospital	☐ Other: ____________
Sinus Lift	☐ Office	☐ Hospital	☐ Other: ____________
TMJ Surgery	☐ Office	☐ Hospital	☐ Other: ____________
Uvulopalatoplasty	☐ Office	☐ Hospital	☐ Other: ____________
Other: ____________	☐ Office	☐ Hospital	☐ Other: ____________
Other: ____________	☐ Office	☐ Hospital	☐ Other: ____________

☐ I do not perform any surgical procedures or treatments	Initial to confirm: ___________________________

24) Do you use analgesia, sedation, or anesthesia on patients? Yes ☐ No ☐

a. If yes, is application local only? Yes ☐ No ☐

25) If you perform any of the following types of anesthesia, please complete the below table:

	Inhalation Conscious	Oral Conscious	Parenteral Conscious	Parenteral Deep Sedation	General Anesthesia
Percent of patients under 18					
Drug(s) Used					
Office, Surgi-Center, or Hospital Setting					
Administered by:	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________	☐ You ☐ Oral Surgeon ☐ Physician Anesthesiologist ☐ Dentist Anesthesiologist ☐ CRNA ☐ RN/LPL ☐ Other: ________

26) Do you adhere to Harvard Standards for anesthesia administration? Yes ☐ No ☐

27) Do you hold an ALCS certificate? Yes ☐ No ☐

28) Which of the following emergency treatment items do you have available? Check all that apply:

☐ Oral Airway ☐ Ambu bag ☐ Endotracheal tubes/scopes

☐ Oxygen ☐ Emergency Drugs ☐ None Available

☐ Other: ________________ ☐ Other: ________________ ☐ Other: ________________

STAFF INFORMATION

29) Please complete the following for your staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
Dental Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Dental Technician					Yes ☐ No ☐	Yes ☐ No ☐
Hygienists					Yes ☐ No ☐	Yes ☐ No ☐
Physician*					Yes ☐ No ☐	Yes ☐ No ☐
Physician Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Surgeon Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Lab Technician					Yes ☐ No ☐	Yes ☐ No ☐
Pharmacist					Yes ☐ No ☐	Yes ☐ No ☐
RN, LPN					Yes ☐ No ☐	Yes ☐ No ☐
CRNA					Yes ☐ No ☐	Yes ☐ No ☐

X-Ray Technician					Yes ☐ No ☐	Yes ☐ No ☐
Other: ____________________					Yes ☐ No ☐	Yes ☐ No ☐

** Requires separate application*

COVERAGE AND LOSS HISTORY

30) Has any licensing authority or professional association taken any action against you or any of your employees? **If yes, please attach an explanation and copies of all citations.** Yes ☐ No ☐

31) In the last 12 months have you or any of your employees been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

32) Do you have Professional Liability insurance in place for work you do elsewhere? **If yes, please attach a copy of the policy Declarations page(s).** Yes ☐ No ☐

33) Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

34) If your Professional Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

35) If your Commercial General Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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 commits a fraudulent insurance act, which is a crime.

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

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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.

NOTICE TO TENNESSEE APPLICANTS: 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.

NOTICE TO VIRGINIA APPLICANTS: 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: ______________________________ Title: ______________________

FEIN #: ____

Applicant's Signature: _______________________ Date: ______________________

Agent/Broker Name: ____