623 SW 10th Avenue
Topeka, KS 66612
800-232-2259
www.kammco.com

Dentist Application for Claims-Made Professional Liability Insurance
New Business

Application Instructions & Required Information

- Answer all questions completely and accurately.
- Complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, use the **Comments** section at the end of this application or attach separate documentation.
- Sign and date the application where indicated.
- Provide claim information for the last five years and include current company loss runs.

Requested Effective Date (MM/DD/YYYY): _____

A. Applicant Information

Agency Name (if applicable): _____

Applicant's Name (First, Middle, Last): _____

Date of Birth (MM/DD/YYYY): _____ **Social Security Number:** _____

Designation: ☐ Dentist ☐ Other (specify below)
Specify Other: _____

Gender: ☐ Male ☐ Female

Applicant's Business Information

Street: _____ City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Fax: _____ Email: _____

Applicant's Home Information (P.O. Box not accepted)

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Applicant's Billing/Mailing Information ☐ Home ☐ Business ☐ Other (specify): _____

Street: _____ City: _____ State: _____ Zip: _____

Name of Business Manager / Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other

B. Current Coverage

1. Existing Form of Insurance: ☐ Occurrence ☐ Claims-Made

If Claims-Made, what is your retroactive date? (MM/DD/YYYY): _____

2. List your insurance coverage for the past five years:

Carrier Name	Policy #	Coverage Dates	Limits	Retroactive Date

C. Requested Coverage

1. Limits of Liability (Limits are expressed as per claim and annual aggregate)

Select One: ☐ $500,000 / $1,500,000 ☐ $1,000,000 / $3,000,000

D. Practice Information

1. If you are employed, indicate the name of your employer: _____

2. If you are an independent contractor, name each entity with which you have contracted dental services:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

3. List each professional corporation, association, partnership, or other healthcare-related entity in which you have an ownership.

(Complete one Corporate Healthcare Application for each organization listed below, if coverage is desired.)

Name	Description of Interest	% of Practice

4. If you, as an individual, employ or contract with other medical professionals, complete the following:

Type	Number	Employment	Current Insurer
Licensed Dentists, Oral Surgeons or MDs		☐ Employee ☐ Contractor	
Dental Hygienist		☐ Employee ☐ Contractor	
Technicians		☐ Employee ☐ Contractor	
Nurses (including CRNAs)		☐ Employee ☐ Contractor	

E. Education, Training, and Work Experience

1. Provide the following information about your school of graduation.

Name of School: _____

City & State of School: _____

Year of Graduation: _____

2. How many years have you been practicing Dentistry: _____

3. List your professional degree(s): _____

4. Are you certified by an approved specialty board? ☐ Yes ☐ No

If yes, certifying board name(s): _____

Date(s) of initial certification: _____

Date(s) of recertification: _____

5. If you are not certified, are you board eligible? ☐ Yes ☐ No

If yes, date eligibility expires: _____

6. List each state where you are licensed to practice as well as your license number.

State	License Number

7. List all the places where you have practiced your profession during the past five years.

Facility / Practice Name	City	State	Dates (MM/YY to MM/YY)
			_____ to _____
			_____ to _____
			_____ to _____
			_____ to _____

8. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No

If yes, describe the changes below.

F. Classification

1. Provide information about the character of your practice. Check all that apply and indicate what percentage of your practice they compose.

_____ % ☐ General Dentistry		_____ % ☐ General Dentistry Limited (e.g. TMJ, Implants)	
_____ % ☐ Dental Public Health		_____ % ☐ Oral Surgery	
_____ % ☐ Pediatric Dentistry		_____ % ☐ Endodontics	
_____ % ☐ Faculty – Intramural		_____ % ☐ Prosthodontics	
_____ % ☐ Faculty – Non-Intramural		_____ % ☐ Oral Pathology	
_____ % ☐ Periodontics		_____ % ☐ Orthodontics	

Questions 2–5 pertain to your use of anesthesia and analgesia.
Make certain you read and answer all questions carefully.

If you answer **"yes"** to question 2, 3, 4 or 5 you must completed the **Anesthesia / Analgesia Questionnaire** attached to this application.

2. Do you limit your practice to local anesthesia and/or oral medication? ☐ Yes ☐ No

3. Is nitrous oxide used when treating patients? ☐ Yes ☐ No

4. Are you treating patients who are under conscious sedation?
(Note: For purposes of this insurance application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.) ☐ Yes ☐ No

5. Are you treating patients who are under general anesthesia (deep sedation)? ☐ Yes ☐ No

G. Underwriting Questions

Explain any **"yes"** answers to any of the questions in this section in the **Comments** section at the end of this application.

1. Has your license to practice dentistry ever been denied, revoked, suspended, voluntarily surrendered, or subject to investigation or probationary terms in any jurisdiction? ☐ Yes ☐ No

2. Has your license to prescribe or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered, or subject to investigation or probationary terms? ☐ Yes ☐ No

3. Has your membership in any dental society, specialty board, or professional organization ever been denied, suspended, revoked, voluntarily surrendered, or subject to investigation or probationary terms? ☐ Yes ☐ No

4. Have you ever been, or are you currently, the subject of investigation, disciplinary proceedings, or reprimand by any administrative agency, licensing entity, dental society, hospital, or professional organization? ☐ Yes ☐ No

5. **Has any application for hospital staff privileges ever been denied or granted with restrictions or conditions?** ☐ Yes ☐ No

6. **Have your hospital privileges ever been modified, revoked, or non-renewed?** ☐ Yes ☐ No

7. **Have you been subject to probation or disciplinary action related to your hospital privileges?** ☐ Yes ☐ No

8. **Have you ever had board certification refused or revoked?** ☐ Yes ☐ No

9. **Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?** ☐ Yes ☐ No

10. **Has your professional liability insurance ever been declined, canceled, refused, non-renewed, or issued on special terms?** ☐ Yes ☐ No

11. **Has any administrative agency, licensing entity, hospital, or professional organization ever requested you be examined or evaluated by a physician because of an alleged mental condition, alcohol abuse, or drug dependency?** ☐ Yes ☐ No

12. **Have you ever had an illness or physical disability that impairs or could tend to impair your ability to practice dentistry or could put your patients at risk?** (e.g. alcoholism, convulsive disorders, Hepatitis B, HIV positive, mental illness, multiple sclerosis, narcotics addition, rheumatoid arthritis, etc.) ☐ Yes ☐ No

    If you answered yes:

    a) State your illness or disability in the **Comments** section at the end of this application.

    b) Include a statement from your physician that attests to your fitness to practice and includes the complete details of your illness or disability.

13. **Have you ever been treated for alcohol or drug addiction or mental illness?** ☐ Yes ☐ No

H. Claim Information

Explain any **"yes"** answers to any of the questions in this section in the **Comments section** at the end of this application.

1. **Have any claims or lawsuits ever been made against you, the owners of your practice/facility, or your employees or contractors that arose out of the performance of professional services rendered – or which should have been rendered – by any person for whose acts or omissions you are legally responsible?** ☐ Yes ☐ No

    If yes, indicate the number of previous and/or pending claims or lawsuits: _____

    Please complete the **Claim Information Worksheet** (attached to this application) for each claim or lawsuit indicated above. Make additional copies as needed.

I. Comments

Add comments in the space below. Include the Section and Question Number you're referencing.
If you need additional space, attach additional documentation to this application.

Disclosure Statement and Authorization for the Release of Information

Execution of this application by the applicant does not bind KAMMCO to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

If a policy is issued, the policy will be issued on a claims-made basis and will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy.

The applicant represents the statements and answers made herein are true, and makes the same for the purpose of inducing KAMMCO to issue the policy for which application is hereby made. It is understood that this entire policy shall be void if, whether before or after a loss or claim, the applicant has intentionally concealed or misrepresented any material fact or circumstance concerning the insurance or subject thereof.

I hereby authorize KAMMCO to release the information on this application and associated underwriting information to any insurability committee(s) established by the American Dental Association and/or my state dental society. I consent to the review of any incident or occurrences likely to

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

_____

Signature of Applicant

_____

Date (MM/DD/YYYY)

Please return this application, along with any necessary attachments,
by email to underwriting@kammco.com or by fax to **785.232.4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.

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Anesthesia Addendum

Complete this form **ONLY** if you have answered **"Yes"** to questions 2, 3, 4, or 5 in Section F of the **Dental Professional Liability Application**. Return this form as an attachment to the **Dental Professional Liability Application**.

In this questionnaire, "anesthesia" means any form of inhalation, intravenous or other intramuscular anesthesia or analgesia and/or any combination thereof. The following definitions of **conscious sedation** and **general anesthesia** are provided:

CONSCIOUS SEDATION – is a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof. For purposes of this insurance application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

GENERAL ANESTHESIA (to include deep sedation) – is a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

A. Specify the type of anesthesia/analgesia used when treating patients under conscious sedation.
(When used in combination with other anesthetic or analgesic agents)

1. Inhalation: _____ Nitrous Oxide (when used in combination with other anesthetic or analgesic agents): _____ Other: _____
2. Intravenous: _____
3. Intramuscular (including submucosal): _____
4. Combination: _____
5. Where are conscious sedation procedures performed?

☐ Office Only ☐ Hospital Only ☐ Both Office & Hospital

B. Specify the type of anesthesia/analgesia used when treating patients under general anesthesia.
(When used in combination with other anesthetic or analgesic agents)

1. Inhalation: _____ Nitrous Oxide (when used in combination with other anesthetic or analgesic agents): _____ Other: _____
2. Intravenous: _____
3. Intramuscular (including submucosal): _____
4. Combination: _____
5. Where are conscious sedation procedures performed?

☐ Office Only ☐ Hospital Only ☐ Both Office & Hospital

C. How many years have you used conscious sedation or general anesthesia in your office? _____

D. In your office, how many times per week (on average) do you use conscious sedation or general anesthesia? _____

E. Please specify the type of major and minor surgical procedures performed while treating patients under conscious sedation or general anesthesia.

Major Surgical Procedures:

Minor Surgical Procedures:

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

1. Hospital training in the use of general anesthesia? _____
2. University training in the use of general anesthesia? _____
3. Hospital training in the use of general sedation? _____
4. University training in the use of conscious sedation? _____
5. Other types of training (i.e., Continuing Education programs):

G. I am certified by, or am a member of, the following organizations that require training in general anesthesia:

☐ AAOMS ☐ ABOS ☐ Fellow, ADSA ☐ Member, ADSA

☐ Other (specify): _____

H. I am equipped and trained to use the following emergency procedures:

☐ Positive Pressure Endotracheal Respiratory Assistance

☐ Intravenous Emergency Medications

☐ External Cardiac Massage

☐ Other (specify): _____

I. What type of emergency equipment do you have in your office?

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Claim Information Worksheet

(Make additional copies, if necessary.)

No Claims: ☐ *(A signature is required, regardless of claim history.)*

Applicant's Name (First, MI, Last): _____

Patient's Name (First, MI, Last): _____ Patient's Gender: ☐ Male ☐ Female

Allegation:

Date of Incident (MM/DD/YYYY): _____ Date Reported (MM/DD/YYYY): _____

Insurance Carrier: _____ Location of Incident: _____

Was a lawsuit filed? ☐ Yes ☐ No Are/were you the primary defendant? ☐ Yes ☐ No

If you are/were not the primary defendant, please describe your involvement in the patient care:

Additional Defendants: _____

Claim Status: ☐ Open ☐ Closed Date Closed (MM/DD/YYYY): _____

If open, indicate the reserve amount. *(Required)* _____

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment

b. Amount of settlement or judgment: $ _____

I understand information submitted herein becomes part of my **Professional Liability Insurance Application** as submitted.

_____ _____

Signature **Date**

Please return this form, along with your application, or email it directly to underwriting@kammco.com.
If you work with a KAMMCO guest agent, please submit directly to your agent.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they