Entity Supplement (Entity Includes Any Dental Corporation, Partnership, Group Or Other Legal Entity)

FORTRESS

THIS FORM IS REQUIRED TO BE COMPLETED FOR A SEPARATE ENTITY POLICY TO BE ISSUED AS REQUESTED ON PAGE 4 OF THE INDIVIDUAL APPLICATION, PER SECTION VI ENTITY AFFILIATIONS. **PLEASE SUBMIT A COPY OF THE ENTITY'S ARTICLES OF INCORPORATION OR ARTICLES OF ORGANIZATION.**

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 (NOTE: The coverage type and limits of the entity policy must be the same as the underlying individual coverage)

1. Requested Effective Date: ______________________
2. Coverage Type: ☐ Claims-Made ☐ Occurrence
3. If Claims-Made coverage is requested, please indicate if prior acts coverage is desired: ☐ Yes ☐ No
   If yes, please indicate your Retroactive Date: ______________________
   Please submit your current professional liability declarations page
4. Limits Requested (each person/aggregate limit):
   ☐ $250,000/$750,000 ☐ $500,000/$1,000,000 ☐ $1,000,000/$3,000,000
   ☐ $2,000,000/$6,000,000 ☐ $3,000,000/$6,000,000
5. Please list all of your previous entity professional liability insurers for the past 10 years:

Insurance Company	Coverage Type	From (Month/Year)	To (Month/Year)
______________	☐ Claims-Made ☐ Occurrence	__________	__________
______________	☐ Claims-Made ☐ Occurrence	__________	__________
______________	☐ Claims-Made ☐ Occurrence	__________	__________

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

	Name / Affiliation Code	Specialty	Insurance Carrier	Is this the dentists primary practice location? (Y/N)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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.

WARNING

Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud. Such person may be subject to denial of insurance benefits, civil penalties and/or criminal penalties.

In CO: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant 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.

In KY: Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

In PA: 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 a person to criminal and civil penalties.

In VA & ME: 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

In FL: 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 certify that 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 ______________

Agent Signature: ______________________________

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

Agent Signature: ______________________________

Claim Supplement Form

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: $______________________

Agent Signature: ______________________________