CBMALAGA
Insurance Services LLC

1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

Dental Corporation Professional Liability Insurance Application

With your fully completed, signed and dated application, you must submit the following information:

1. Current insurance policy declarations page.
2. Copy of extended reporting endorsement (tail) from your current carrier if your current coverage is claims-made and you are *not* applying for prior acts coverage.
3. Loss runs from all prior insurance companies or explanation as to why they are not available.
4. Current business letterhead.

1. Organization Information

Organization Name: _____

Federal Tax ID: _____-_____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Preferred Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ Email: _____

Is this contact the authorized representative for access to policy information? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative. _____

Please list additional practice locations:

Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership
☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other _____

B. Has the Organization ever been incorporated under a name other than that listed above? Yes ☐ No ☐
If yes, please list all previous names and the first use date of each:

_____

C. Is or has the Organization ever been incorporated in a state other than that listed above? Yes ☐ No ☐
If yes, please list states and first use date in each:

_____

D. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

2. Coverage Information

A. Requested Effective Date: _____ / _____ / _____
MONTH DAY YEAR

B. Requested Limits[1]

i. ☐ Shared Limits ☐ Separate Limits

ii. If requesting separate limits:

a. Primary Coverage Limits: _____

b. Excess Coverage Limits: _____

C. Is the organization requesting Prior Acts Coverage? Yes ☐ No ☐

Requested Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

3. Insurance History and Claims Information

A. Current Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Have any claims or suits ever been filed against your organization as a result of professional services? Yes ☐ No ☐

D. Are you aware of any conduct, circumstances, occurrences, or incidents likely to give rise to a claim? Yes ☐ No ☐

E. If you are answered "yes" to question 3.C. or D., have the claims, conduct, circumstances, occurrences, or incidents been reported to a previous insurer? (Please complete the Supplementary Claims information form at the end of this application.) Yes ☐ No ☐

F. Has the Organization (or those listed in 1.B.) ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance? Yes ☐ No ☐

G. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes ☐ No ☐

[1] Limit options vary by state

4. Practice Information

A. List all healthcare providers, members, shareholders, partners, owners, employed dentists and independent contractors in the organization. It is the policy of the Company to insure all dentists who are employees, partners, shareholders and/or owners of a corporation. **All affiliated dentists must complete an application.**

Name: _____ Please check any that apply:

Specialty: _____ ☐ Member ☐ Owner ☐ Shareholder

Start Date: _____ ☐ Employee ☐ Partner ☐ Independent Contractor

Current Insurer: _____ ☐ Other _____ Hrs/Week

Name: _____ Please check any that apply:

Specialty: _____ ☐ Member ☐ Owner ☐ Shareholder

Start Date: _____ ☐ Employee ☐ Partner ☐ Independent Contractor

Current Insurer: _____ ☐ Other _____ Hrs/Week

You must provide proof of coverage for each dentist insured elsewhere.

B. Do you employ any of the following? Yes ☐ No ☐
If yes, indicate the number in each category:

Dental Assistant: _____ Dental Technician: _____ Dental Hygienist: _____

GENERAL FRAUD WARNING – Any person who, with intent to defraud or knowing that he 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.

Applicant's Signature: _____ Title: _____

Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

For Agent's Use Only (if applicable)

	CB Malaga Insurance Services LLC - www.cbmalagains.com
Agent's Name	Agency Name
Signature	Agency Address
	1-877-245-5887
Date	Phone

Additional Comments

Dental Corporation Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Name and Address of the Attorney assigned to your case: _____

   _____
5. Date of Incident and your treatment: _____
6. Allegations: _____

   _____

   _____
7. What is the present condition of the patient? _____

   _____

   _____
8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes ☐ No ☐
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed, but dropped by claimant	☐ Jury verdict	☐ Awaiting court action
☐ Summary Judgment in your favor	☐ Directed verdict	Reserve Amount: _____
☐ Suit settled Out-of-Court	☐ Court outcome in favor of plaintiff	
Date claim paid: _____	☐ Jury verdict	
Amount paid: _____	☐ Directed verdict	
	Amount of Loss: _____	

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
    If yes, amount was: $_____

Name (Printed): _____

Signature: _____ Date: _____