AMERICAN ASSOCIATION OF ORTHODONTISTS INSURANCE COMPANY (AAOIC), *A Risk Retention Group*

This policy is issued by your risk retention group. Your risk retention group may not be subject to all the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

Home office: Scottsdale, AZ *If you have any questions, please call 800-622-0344*

INSTRUCTIONS TO APPLICANT

ALL QUESTIONS MUST BE ANSWERED COMPLETELY. PLEASE TYPE OR PRINT CLEARLY IN INK.

A. The application and all supplemental forms must be signed in ink and dated by the applicant.
B. If you request prior acts coverage, proof of continuous claims-made coverage must be submitted with the application
C. **Please attach a copy of :**
1. Current Dental License in the State(s) you practice
2. Copy of your Master's degree or orthodontic certificate from an ADA/CDA accredited residency program
3. Informed Consent Form that you use

* **Upon approval, coverage may become effective no earlier than the date the application is received in our office. Although an application may be faxed, the application cannot be considered for approval until the original signed application, all supplemental forms and premium payment are received.**

PART I GENERAL INFORMATION (TO BE NAMED ON THE POLICY)

1. Name of applicant: Last	First	Middle	Gender ☐ Male ☐ Female	Date of Birth M_____D_____Y_____

Name(s) of corporation, partnership, association, limited liability company, or other legal entity to be insured under this policy:

Are you a partner, officer, director, or shareholder in a professional partnership, corporation, association, other legal entity, or a member of a limited liability company for which you provide professional dental or orthodontic services to patients? Yes ☐ No ☐

If you answered 'Yes' to the above question, you **MUST** have your professional partnership, association, corporation, limited liability company or other legal entity insured and **NAMED** on your policy. **If your professional partnership, association, corporation, limited liability company, or other legal entity is NOT NAMED on your policy, you will have no coverage for that legal entity**. If there is a reported claim or suit against you and the professional legal entity, when our duty to defend ends, you and said partnership, association, corporation, limited liability company, or other legal entity will both be legally responsible, jointly and severally, for reimbursing AAOIC for the attorney's fees, expenses and costs we have paid to defend the legal entity in the claim or **Suit.**

AAOIC will **only** provide coverage for the individual and legal entity(ies) that you name above. Are you sure this information is correct and complete? Yes No

***Please complete the Professional Associations, Partnerships, Corporations, Limited Liability Companies or Other Legal Entities Supplemental Application for EACH legal entity.**

2. Education:

a. Dental School: _____Year Graduated:_____

b. Orthodontic Program:_____Year Graduated:_____

3. Primary Office Location:

Street				**Total practice hours per week in this office:**
City	County	State	Zip Code	Applicant's Email Address:
Primary Office Phone Number	Applicant's Cell Number		Emergency Contact/Relationship	

4. Secondary Office Location: *(if additional office locations, please note below)*

Street			**Total practice hours per week in this office:**
City	County	State	Zip Code
Secondary Office Phone Number	Fax Number all locations	Office Business Manager Contact all locations	

5. **Mailing Address:** ☐ Primary Location ☐ Secondary Location

Home Address: _____

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Additional office locations and practice hours per week:

PART II FACULTY PRACTICE

6. a. Do you teach or supervise students in any graduate orthodontic program? Yes ☐ No ☐
If **Yes,** please indicate which program: _____
If **Yes**, are you full-time faculty _____ or part-time faculty _____?

b. Does this program provide you with professional liability insurance for your clinical supervision of students? Yes ☐ No ☐

c. If **No**, are you requesting insurance for the clinical supervision of students? Yes ☐ No ☐
If you are requesting insurance, list the address above or by separate page.

PART III INFORMATION ABOUT THE INSURANCE FOR WHICH YOU ARE APPLYING

Are you a recent orthodontic graduate (within the last 24 months)? Yes ☐ No ☐

Are you an applicant with prior professional liability insurance coverage? Yes ☐ No ☐ (if **No**, continue to question #8)

7. What is your current policy form? Occurrence _____ Claims-Made _____

8. I am requesting with AAOIC: Occurrence _____ Claims-Made _____

Requested Effective Date with AAOIC: _____ If Claims-Made, Requested Retroactive Date:_____

a. If you are requesting occurrence coverage, list below the previous insurance companies for the past five years.
b. If choosing occurrence coverage for an expiring claims-made policy, have you purchased tail coverage for the expiring policy? Yes ☐ No ☐
c. If you are requesting claims-made coverage, list below the previous insurance companies for the term of retro coverage that you are seeking and attach a current copy of your policy declaration page.
d. Complete and sign the **Prior Acts Supplemental Application** for Claims Made coverage **replacing an active** Claims Made policy.

Company Name	From	To	Type	Limits	Retro Date	Premium

9. Limits of Liability requested: (occurrence/aggregate) please select one:

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ $2,000,000/$5,000,000

☐ $2,000,000/$6,000,000 ☐ $3,000,000/$3,000,000 ☐ $4,000,000/$4,000,000 ☐ $5,000,000/$5,000,000

☐ $100,000/$300,000 (Louisiana only) ☐ $500,000/$1,500,000 (Indiana only) ☐ $2,500,000/$7,500,000

☐ $3,000,000/$6,000,000

PART IV APPLICANT AND PRACTICE INFORMATION

10. Current Dental License information (all states where licensed) Dental NPI # _____

State:	License #:	Date Licensed:	Expiration Date:

11. a. Business structure in which you practice (check all that apply). If you request Additional Insured coverage, please see question 12.

a. A Solo Practice (sole proprietor unincorporated)
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

b. A Solo Practice (incorporated)
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

c. Partnership (unincorporated)
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

d. Multi-Disciplinary Practice owned by orthodontists
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

e. Multi-Disciplinary Practice owned by a general practitioner
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

f. Multi-Doctor Corporate Practice (2+orthodontists)
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

g. Dental Service Organization
- ☐ Practice owner
- ☐ Employee
- ☐ Independent contractor

12. Are you requesting **additional insured** coverage for a legal entity in which you do not have an ownership interest including but not limited to DSO's or OSO's? Yes ☐ No ☐ **If yes, provide the entity name below.**

Name of **additional insured**: _____
Coverage for **additional insureds** must be shared with the applicant's limits of liability.

13. Do you practice orthodontics exclusively? Yes ☐ No ☐

If **No**, please explain: _____

14. Answer the following: (**If the answer is YES** to any of the questions below, use space provided at the end of this application or on a separate page explaining the details, label it "**Applicant Information Question #13", and initial here:_____.)**

a. Have you ever been treated for alcoholism, narcotics addiction, mental illness physical impairment? Yes ☐ No ☐
b. Have you been the subject of any investigation by a local, state or national dental organization or government agency? Yes ☐ No ☐
c. Have you ever been the subject of any disciplinary action by a local, state or national association? Yes ☐ No ☐
d. Have you ever had any state license or federal narcotic license revoked, suspended or voluntarily surrendered? Yes ☐ No ☐
e. Have you ever had your membership in a professional association refused, suspended or revoked? Yes ☐ No ☐
f. Have you ever been charged or convicted of any criminal acts, including DUI of alcohol or drugs (other than minor traffic offenses)? Yes ☐ No ☐
g. Do you know of any incident, fact, circumstance, act, error or omission that may result in a professional liability claim involving you? Yes ☐ No ☐
h. Have you ever had your request for professional liability insurance refused, your insurance cancelled or non-renewed? Yes ☐ No ☐
i. Do you or your practice consult with, endorse, or receive any compensation from any direct-to-consumer orthodontic treatment providers? Yes ☐ No ☐
There is no coverage related to these services under AAOIC's policy.
j. Have any professional liability claims or lawsuits been brought against you at any time in the past? Yes ☐ No ☐
If **Yes,** please complete the **Claims Information Supplemental Application** for each claim or lawsuit.

Please indicate the number of claims/lawsuits# _____

PART IV (cont.) APPLICANT AND PRACTICE INFORMATION

15. Do you obtain a medical and dental history on every patient entering active treatment and update them throughout treatment? Yes ☐ No ☐

16. Excluding your current practice, list all locations where you have practiced since your formal dental and orthodontic training. Please explain any lapses in time since professional school.

Institution/Organization Name	**Dates: From/To**

17. Do you administer general anesthesia and/or sedation? Yes ☐ No ☐
There is no coverage related to these services under AAOIC's policy.

18. Do your extraoral force systems employ patient safety mechanisms? Yes ☐ No ☐ Do not use ☐
If **No,** please explain: _____

19. Please indicate the number the number of support personnel in your practice:
_____ a. Dental Hygienist _____ d. Dental Assistant _____ f. General Dentist
_____ b. Orthodontist _____ e. Clerical _____ g. Lab Technician
_____ c. Other (Describe) _____

20. Please describe your practice:

a. Do you have control of the staff activity? Yes ☐ No ☐
b. Do you exercise control over the staff hiring & discharge? Yes ☐ No ☐
c. Do you have control over the treatment plans for the patients? Yes ☐ No ☐
d. Do you have the authority to request progress records during treatment? Yes ☐ No ☐

If **No,** to any of the questions, please explain: _____

21. a. Average number of patients seen per day: _____
b. Total number of active patients in treatment: _____

22. Other than on an emergency basis in your practice are multiple orthodontists treating the same patients? Yes ☐ No ☐

23. What orthodontist(s) has/have agreed to provide coverage for your practice in the event of your death or disability?
Name: _____
Name: _____
Name: _____

Additional Information:

SHAREHOLDER PROXY

To facilitate the business of the American Association of Orthodontists Insurance Company ("AAOIC"), the AAOIC Board of Directors requests your proxy to vote for Director candidates as well as to transact any business which is properly presented at the AAOIC annual shareholders meeting. You may revoke your proxy at any time prior to or at the Shareholders meeting. **(Your proxy is *not* a condition of renewal of your insurance).**

I agree to assign my proxy to the AAOIC Board of Directors to facilitate the business of the Company until revoked or I am no longer a shareholder. Yes ☐ No ☐

PART V DUTIES AND OBLIGATIONS OF APPLICANT

Please Read Carefully

The Applicant represents to the American Association of Orthodontists Insurance Company (AAOIC) *a Risk Retention Group*, that the information submitted in this application and attachments were carefully compiled by the Applicant, or under the Applicant's supervision, that they are true, complete, and current as of the date submitted, **that the applicant will maintain membership in the AAO and that the applicant consistently utilizes the AAO/AAOIC Comprehensive Informed Consent document, and supplemental informed consent documents when appropriate, all of which are available at AAOIC.com.**

The execution and submission of this Application shall not bind AAOIC or its agents to the issuance of insurance, nor shall it bind the Applicant to the acceptance of a policy. However, in the event a policy is issued by AAOIC and accepted by the Applicant, all of the representations in this Application shall be binding upon the Applicant.

AAOIC reserves the right to amend the terms, conditions and limitations of any policy issued as a result of this Application. In the event of any change in the information supplied on this Application, the Applicant agrees to immediately provide written notice to AAOIC.

The Applicant authorizes all former liability insurers to furnish AAOIC with all available information concerning the Applicant. The Applicant agrees that the release of such information, even if erroneous or partial, shall not result in liability to any such party.

The statements and agreements made in this Application are fully incorporated into and become a part of the policy, if issued.

FRAUD WARNING NOTICE:
Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information, is guilty of a crime.

INDIVIDUAL APPLICANT

_____ _____ _____
Signature of Individual Applicant *AAO Member #* *Date*

_____ _____
Authorized Signature of Corporate Representative (if applicable) *Date*

_____ _____
Signature of Agent *Date*

Application Checklist **PLEASE REVIEW**

1. Complete **ALL** questions and sign the application.
2. Include a copy of your current dental license and orthodontic certificate.
3. Include a copy of the Informed Consent document that will be consistently used in your practice.
4. Include a copy of the signed & dated Participation and Shareholder's Agreements.
5. Include the following forms if required : Application for Prior Acts coverage; Application for Corporation/Partnership coverage and a verification of coverage letter (dated within the past 30 days) from your **current** insurance carrier, which must include a complete Loss History.

Return Application to:

American Association of Orthodontists Insurance Company
c/o Pearl Insurance Group, LLC
1200 East Glen Avenue
Peoria Heights, IL 61616-5348

OR

Your Representatives:
Jordan.Halstead@pearlinsurance.com
Phone: (309) 679-0382

Megan.Sharpshair@pearlinsurance.com
Phone: (309) 679-0586