

PART-TIME SUPPLEMENT

To be completed if you are requesting Part-Time coverage.

Are you a full-time academician? Yes No

Name of institution: _____

If yes, attach documentation from the institution verifying your full-time status and coverage at the institution.

Are you a full time student? Yes No

If yes, attach a letter from the registrar which verifies your enrollment.

Are you disabled? Yes No

If yes, please explain your disability on a separate sheet of paper and submit medical documentation from your physician.

Estimate the total number of hours per average week devoted in your practice to:

- | | |
|--|---|
| A. Actual patient care _____ | D. Administrative duties for the office _____ |
| B. Actual patient record-keeping _____ | E. Training of dental students _____ |
| C. Consulting _____ | (in a accredited program) |

Indicate the hours you are available for direct patient care in your office:

Monday	From	_____	To	_____
Tuesday	From	_____	To	_____
Wednesday	From	_____	To	_____
Thursday	From	_____	To	_____
Friday	From	_____	To	_____
Saturday	From	_____	To	_____

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.

DID YOU KNOW?

◆ **Risk Management Credit**

Attendance at an approved risk management seminar in the last year provides a credit on your premium.

◆ **Contractual Liability**

We will not pay or defend against any liability you have assumed under any contract or agreement unless such liability is otherwise covered by our Policy, and:

- (1) You would have been liable for damages without regard to the contract or agreement; or
- (2) You have assumed liability for damages under a contract of agreement with (a) a Health Maintenance Organization; (b) a Preferred Provider Organization; (c) an Independent Practice Organization; or (d) a similar managed care or health care provider organization.

If you have entered into a written or oral agreement with another party, it is strongly recommended that you consult with your personal attorney to determine if there are any deficiencies which may subsequently impact on your professional liability insurance coverage.

◆ **AIDS/HIV**

Please note that it may be contrary to state or local law to ask questions pertaining to AIDS/HIV or the use of illegal drugs on your medical history form. We strongly recommend that you review your medical history form with your attorney.

◆ **Parenteral Conscious Sedation and General Anesthesia**

If parenteral conscious sedation and/or general anesthesia is administered by you, a CRNA or any other person or organization for whose acts or missions you are legally responsible in your office, you will be considered a class II specialist. Your limits of coverage must be \$1,000,000 per patient/\$3,000,000 total limit, and your CRNA must provide evidence of professional liability coverage.

If parenteral conscious sedation and/or general anesthesia is administered by a state recognized dental/medical anesthesiologist or oral and maxillofacial surgeon in your office, there may not be an addition premium charge or a requirement to increase you limit of coverage to \$1,000,000 per patient/\$3,000,000 total limit subject to receipt of the following additional information for the healthcare provider(s): (1) name and professional specialty and (2) certificate of professional liability insured. (Note: minimum limits of \$1,000,000/\$3,000,000 is required).