AUSTRALIA
CANADA
IRELAND
ISRAEL
**UNITED KINGDOM**
UNITED STATES
REST OF WORLD

# DENTAL MALPRACTICE

## APPLICATION FORM

## INTRODUCTION

The purpose of this application form is for us to find out more about you. Completion of this application form does not oblige either you or us to enter into a contract of insurance.

Following a reasonable search you must provide us with all information which may be material to the cover we offer in a clear and accessible manner. Information is material if it would influence our decision whether to insure you, what cover we offer you or what premium we charge you. If you are in any doubt whether a fact or circumstance is material you should disclose it.

## HOW TO COMPLETE THIS FORM

This form should be completed by the applicant who should make all the necessary enquiries to enable our questions to be answered

If you require extra space to answer the questions or provide any other material information, please use the additional information section at the back of the form. Once you have completed the form please return it directly to your insurance broker.

## SECTION 1: PERSONAL DETAILS

1.1 Please provide the following details:

Full name: Date of birth:

Practice address:

Postcode:

Home address:

Postcode:

Mobile telephone number: Practice telephone number:

E-mail:

Nationality: Gender:

## SECTION 2: QUALIFICATIONS

2.1 Please state:

a) your primary dental qualification and the name of the university and the country where you studied:

Primary dental qualification:

Name of the university/dental school:

Country:

b) the year in which you achieved your primary dental qualification: YYYY

c) what post graduate qualifications you have attained or any areas of specialist training or fellowships:

d) have you been practicing continuously in the UK for the last 2 years? ☐ Yes ☐ No

*If no, please explain:*

e) your GDC Registration Number:

f) the date of original GDC Registration: DD/ MM / YY

g) your current GDC registration status:

h) whether you are a member of any professional association(s): ☐ Yes ☐ No

*If yes, please provide details of which organisations:*

## SECTION 3: YOUR PRACTICE

3.1 Please state whether you are a:

a) Practice Owner/Principal ☐ Yes ☐ No

b) Self-employed associate ☐ Yes ☐ No

c) Salaried employee ☐ Yes ☐ No

3.2 Do you work as a sole practitioner? ☐ Yes ☐ No

3.3 Do you work as a Locum? ☐ Yes ☐ No

*If yes, please state how many practices you cover?*

3.4 Please state the number of sessions you work per week:

3.5 Please provide a breakdown of the split of patients between NHS and Private:

NHS: % Private: %

3.6 Please state your annual gross income (**before expenses**) in respect of the following:

| | Last complete financial year | Estimate for the current financial year |
|---|---|---|
| Dental practice, excluding medico legal work: | £ | £ |
| Medico legal work (ex VAT): | £ | £ |
| Other (*please specify below*): | £ | £ |
| **Total:** | £ 0 | £ 0 |

*If 'other', please provide full details:*

3.7 Approximately how much of your practice relates to paediatric work? %

3.8 Please provide a full breakdown by time spent on the following activities.

The total of all activities listed should equal 100%:

| | | | |
|---|---|---|---|
| General Dentistry: | % | Oral and Maxillofacial Surgery: | % |
| Orthodontics: | % | Implants: | % |
| Endodontics: | % | Legal Report Writing: | % |
| Periodontal: | % | Other *(please specify below)*: | % |
| | | **Total:** | 100% |

*If 'other', please provide full details:*

3.9 Do you undertake any Oral / Maxillofacial Surgery, as detailed below? ☐ Yes ☐ No

If yes, please state which procedures and the number of hours per week:

a) **LEVEL 1 – Surgery involving intra-oral tissues, teeth and tooth carrying bones, including the following procedures:**

i. Exodontia e.g. wisdom teeth removal, apicoectomies ☐ Yes ☐ No *If yes, hours per week*

ii. Minor Cyst removal from hard or soft tissue ☐ Yes ☐ No *If yes, hours per week* ☐

iii. Placement of dental implants (*excluding sinus lifts and bone augmentation which involve the floor of the sinus, or extra bone harvesting, all of which are regarded as maxillofacial procedures*) ☐ Yes ☐ No *If yes, hours per week* ☐

iv. Minor pre-prosthetic surgery ☐ Yes ☐ No *If yes, hours per week* ☐

b) **LEVEL 2 – Surgery involving intra-oral tissues, teeth and tooth carrying bones, including Level 1 procedures as above, but also including sinus lifts and bone augmentation which involves the floor of the nose or sinus, or extra bone harvesting:** ☐ Yes ☐ No *If yes, hours per week* ☐

c) **LEVEL 3 – Surgery involving:**

i. Excision of maxilla ☐ Yes ☐ No *If yes, hours per week* ☐

ii. Extra oral procedures to the face, head and neck including partial thyroidectomy ☐ Yes ☐ No *If yes, hours per week* ☐

iii. Hemimaxillectomy for malignancy ☐ Yes ☐ No *If yes, hours per week* ☐

iv. Neck surgery including block dissection of cervical lymph nodes ☐ Yes ☐ No *If yes, hours per week* ☐

v. Open reduction of zygomatic complex fracture ☐ Yes ☐ No *If yes, hours per week* ☐

vi. Osteotomies (maxilla and/or mandible) ☐ Yes ☐ No *If yes, hours per week* ☐

vii. Prosthetic replacement of temporomandibular joints including arthroplasty ☐ Yes ☐ No *If yes, hours per week* ☐

viii. Reconstruction with axial and micro-vascular tips ☐ Yes ☐ No *If yes, hours per week* ☐

ix. Rhinoplasty ☐ Yes ☐ No *If yes, hours per week* ☐

x. Surgical treatment of thyroid and parathyroid glands ☐ Yes ☐ No *If yes, hours per week* ☐

xi. Surgery involving the orbital complex ☐ Yes ☐ No *If yes, hours per week* ☐

3.10 Please state the proportion of patients where the following procedures are used:

General Anaesthetic: ☐ % Inhalation Sedation: ☐ % IV Sedation: ☐ %

3.11 If you are providing general anaesthetic, please confirm:

a) your premises are licenced for the use of general anaesthetic ☐ Yes ☐ No

b) the appropriate procedures / protocols are in place in the event of a medical emergency ☐ Yes ☐ No

3.12 Do you provide any cosmetic procedures where the primary objective is to improve cosmetic appearance? ☐ Yes ☐ No

*If yes, please state below which procedures, the income earned and the number of hours per week:*

| | Yes | No | Income earned | Hours per week |
|---|---|---|---|---|
| a) Teeth whitening: | ☐ | ☐ | £ | |
| b) Temporary dermal fillers (e.g. Restylane): | ☐ | ☐ | £ | |
| c) Botox: | ☐ | ☐ | £ | |
| d) Other (*please specify below):* | ☐ | ☐ | £ | |

*If 'other', please provide full details:*

3.13 Please state what training you have undertaken in relation to the cosmetic procedures being carried out:

3.14 Are you a member of any cosmetic/beauty association? ☐ Yes ☐ No

*If yes, please provide details of which associations:*

3.15 Please state whether you are registered as a data controller under the Data Protection Act: ☐ Yes ☐ No

*If you hold personally identifiable data on your own electronic system you must be registered with the Information Commissioners Office.*

If you hold electronic data on your patients, please state whether you:

a) have anti-virus software installed and enabled on all of your IT equipment, including desktops, laptops and servers (excluding database servers) and confirm that it is updated on a regular basis: ☐ Yes ☐ No

b) have firewalls installed on all external gateways: ☐ Yes ☐ No

c) take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or whether your outsourced service provider meets this requirement: ☐ Yes ☐ No

3.16 Please state whether you have peer support available to discuss unusual or complex cases which are at the limit of your expertise/experience: ☐ Yes ☐ No

*If yes, please explain what you would do if presented with such a case:*

3.17 Please state whether you plan to retire or cease practice in the UK during the next 5 years: ☐ Yes ☐ No

*If yes, please provide full details including the anticipated date:*

3.18 Do you require cover under this policy for any Dental Care Practitioners? ☐ Yes ☐ No

*If you have answered yes to the above, please provide full details:*

| Name | Role / job title | GDC Number |
|---|---|---|
| | | |
| | | |
| | | |

3.19 Do you undertake any other activities for which cover is required? ☐ Yes ☐ No

*If yes, please provide full details:*

## SECTION 4: INDEMNITY HISTORY REQUIREMENTS

4.1 Please provide details of your current and previous indemnity arrangements covering your private practice and what you now require for this insurance:

| | Retroactive date | Effective date | Limit | Deductible | Premium | Indemnity provider |
|---|---|---|---|---|---|---|
| Previous: | MM / YY | MM / YY | | | | |
| Previous: | MM / YY | MM / YY | | | | |
| Previous: | MM / YY | MM / YY | | | | |
| Current: | MM / YY | MM / YY | | | | |

| | Retroactive date | Limit | Effective date |
|---|---|---|---|
| Now Required: | MM / YY | | MM / YY |

## SECTION 5: CLAIMS EXPERIENCE

5.1 Please answer the following questions in relation to both your UK Practice and any overseas work. Please consider all relevant information and if in doubt, refer to your broker. Regarding all of the types of insurance to which this application form relates.

After full enquiry:

a) have you ever:

i. been subject to any form of disciplinary action or investigation by a regulator, employer or principle? ☐ Yes ☐ No

ii. been subject to any claim, complaint or allegation of negligence (even if the outcome was in your favour)? ☐ Yes ☐ No

iii. been subject to any conditions or suspension to practice by any employer or principal? ☐ Yes ☐ No

iv. been subject to any adverse findings, conditions, suspension or erasure by a regulator, registration body or equivalent? ☐ Yes ☐ No

b) are you aware of any incidents or circumstances which may lead to:

i. any claim, complaint or allegation of negligence? ☐ Yes ☐ No

ii. disciplinary action or suspension from practice? ☐ Yes ☐ No

iii. conditions or restriction on your practice? ☐ Yes ☐ No

iv. removal of your name from a Professional or Regulatory Register? ☐ Yes ☐ No

v. any investigation by a regulator, registration body or equivalent? ☐ Yes ☐ No

c) have you ever suffered a loss of data that has resulted in a privacy breach? ☐ Yes ☐ No

d) have you ever been subject to a Dental Defence Organisation Adverse Member Procedure? ☐ Yes ☐ No

e) have you ever had your membership of a Dental Defence Organisation or similar refused, cancelled or non-renewed? ☐ Yes ☐ No

f) has any insurer ever declined to insured you, imposed special terms, cancelled or declined to renew your insurance? ☐ Yes ☐ No

g) have you ever been convicted of any criminal offence or received a formal caution not spent under the Rehabilitation of Offenders Act 1974? ☐ Yes ☐ No

**If the answer to any of the above is 'yes' then please attach full details including an explanation of the background of events, all relevant dates, the status of the claims or circumstances, the maximum amount involved or claimed and any reserves or payments made.**

## SECTION 6: DECLARATION

I declare that:

- after full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;
- I will inform underwriters before cover incepts of any change to the information supplied by me; and
- I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Signed: _____ Full name: _____

Date: DD / MM / YY

***Data Protection Act*** *– All personal information supplied by you will be treated in confidence by CFC Underwriting Limited and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of CFC Underwriting Limited or our agents or subcontractors.*

ADDITIONAL INFORMATION: