CNA

The Professional Protector Plan®
Property Supplement

Professional Protector Plan® for Dentists

Name: (First/Middle Initial/Last/Designation)	Policy Number	Desired Effective Date
		/ /

PROPERTY INFORMATION (Please complete a separate property supplement for each practice location.)

1. Practice Address: LSJLLC | USVI | 00802
Street | City | County | State | Zip Code

2. Describe the building in which you are located:

Construction of Building you occupy	No. of Stories	Floor on Which You Are Located	Year Built	Total Sq. Footage of Building	Square Footage of Your Office	Square Footage of Basement(s)	Basement(s) Finished	Agent Use Only Protection Class
Cement	1	1	2005	1200	300	200	θ YES ✗ NO	

3. Year building updated (if over 25 years of age) _____:

Year Roof Updated _____
Electric Meets Building Codes _____ Yes _____ No
Plumbing is maintained to prevent exposure to leaking or frozen pipes _____ Yes _____ No
Building was built for a different occupancy and has been modified _____ Yes _____ No If Yes, please describe:
_____

4. Is your practice location equipped with any of the following systems?

	YES Local	YES Central Station	NO
a. Sprinkler	~~θ~~ ✓	θ	θ
b. Fire alarm	~~θ~~ ✓	θ	θ
c. Smoke detectors	~~θ~~ ✓	θ	θ
d. Burglar alarm	θ	θ	~~θ~~ ✓

5. Is your practice located in your residence? ~~θ~~ ✓ Yes θ No
If "Yes," does your office have a separate entrance? ~~θ~~ ✓ Yes θ No

6. What is your practice location's distance to the nearest fire station? 5 miles

7. Do you utilize a watchman service? ~~θ~~ Yes θ No

8. Are cash and checks deposited daily?... θ Yes ~~θ~~ ✓ No

9. How do you store your cash on hand, prescription drugs, precious metals?
~~θ~~ Safe θ Fire Resistive Container θ Other (describe) _____

a. Amount of cash left on premises overnight $ 5000
b. Value of drugs $ 2000
c. Value of metals $ 500
d. Value of other (describe) _____ $ N/A

10. How do you store your accounts receivable records? Computer

11. Do you maintain duplicate accounts receivable records? ~~θ~~ Yes θ No

12. Are accounts receivable duplicates kept off your premises? ~~θ~~ ✓ Yes θ No

DESCRIPTION OF CONTENTS

13. Are you within 1 mile of an ocean, gulf or river? θ Yes θ No

14. Are you less than 10 feet above sea level? θ Yes θ No

15. Total number of operatories: Fully equipped: 1 Partially equipped: _____ Bays: _____

16. Name and address of Loss Payee or Lessor on contents (i.e., office and dental equipment):

Name	Street	City	State	Zip Code
LSJ Dental LLC	6100 Red Hook Quarter B3	St Thomas	USVI	00802
Name	Street	City	State	Zip Code

17. Which coverage do you prefer? θ PPP Standard θ PPP Gold **(Please contact your agent for information on this valuable coverage)**

Estimate the total cost to replace Dental Practice Personal Property:

	PPP Standard	Amount of Coverage Desired
A. Practice Contents:	25,000	
1. Furniture and fixtures		+
2. Operatory equipment		+
3. Instruments and supplies		+
4. Improvements and betterments		+
5. Glass		+
6. Other _____		+
Practice Contents Subtotal (100% Replacement cost)		$ 75,000
B. Practice Records/Charts, Account Receivables, valuable Papers, X-Rays:	$25,000 minimum	+ 25,000
C. Dental Practice Blanket Limit Total (A + B)		+
D. Signs not attached to building	$10,000	+ 10,000
18. Inflation Guard – Dental Practice Personal Property (May select quarterly increase from 1% - 5%)	Optional	_____ % Quarterly
19. Valued Practice Income Minimum daily limit of $300 / 32.5 days		$ _____ / _____ Daily Limit / # days
20. Employee Dishonesty:		
a. money/securities	$10,000	$ 10,000
b. welfare and pension plans	$15,000	$ 15,000
21. Rents (annual rental income)	Optional	$
22. Dentist's Electronic Equipment (including Electronic Data Processing equipment) Do you use surge protection devices? θ Yes θ No	$25,000	$ 25,000
23. Equipment Breakdown Coverage? θ Yes θ No		$
θ Dental Equipment only		$
θ Dental Equipment and Heating,Ventilation & Air Conditioning Equipment		
Do you own the building in which your office is located? θ Yes θ No		
24. Fine Arts (attach appraisals, if additional coverage is desired)	$10,000 subject to maximum $1,000 per item	$

25. Have you had any coverage declined or property losses (fire, burglary, water damage, premises, earthquake, etc.) or employee dishonesty losses during the past **three (3)** years? θ Yes θ No
If **"Yes"**, please give details (cause of loss, amount paid, date of loss) on a separate sheet of paper.

26. Property Deductible - $250 (Optional Deductibles of $500, $1,000, $2,500, $5,000 and $10,000 available (Please contact your agent) $ 2,500

BUILDING INFORMATION - Complete only if you desire insurance on the building through this plan.

27. Building — (Current Cost to Replace)..... $_____
a. additional buildings on premises (garage, storage building)..... $_____
b. inflation guard (may select quarterly increase from 1% - 5%) .. Mandatory _____ %
Quarterly

28. Please indicate % of vacancy, or tenants by type of business and/or operations conducted, and square footage for each:

_____ Sq. feet: _____

_____ Sq. feet: _____

29. Is your building located on a known land subsidence area? ...θ Yes θ No

30. Is your building resting on a saturated man-made (filled ground) or alluvial (soft) soil? ...θ Yes θ No

31. Name of building owner: LSTE LLC

32. Name and address of Mortgagee: N/A

Name Street City State Zip Code

Name Street City State Zip Code

33. Describe the occupant to the right of your building, including distance.	Describe the occupant to the left of your building, including distance.	Describe the occupant to the rear of your building, including distance.
N/A	N/A	N/A

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

10/26/2015

Signature in full: Date

The Professional Protector Plan®

Claims-Made
Professional Liability Insurance For Dentists

THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE WHICH, SUBJECT TO ITS PROVISIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD. NO COVERAGE EXISTS FOR CLAIMS FIRST MADE AFTER THE END OF THE POLICY PERIOD, UNLESS, AND TO THE EXTENT, AN EXTENDED REPORTING PERIOD APPLIES

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant.
3. A copy of your letterhead must be included. Also, please include a copy of all of your "Yellow Pages" advertising, if any.

I agree that any coverage issued will be contingent upon the truth of the following information:

LIMITS REQUESTED:		☒ New Policy Requested Effective Date: 10/26/2015
☐ $1,000,000 / $3,000,000	☐ $3,000,000 / $6,000,000	
☐ $2,000,000 / $3,000,000	☐ $4,000,000 / $4,000,000	☐ Rewrite of Policy Number:
☐ $2,000,000 / $4,000,000	☐ $5,000,000 / $5,000,000	
☐ $3,000,000 / $3,000,000	☐ $5,000,000 / $8,000,000	
☐ Other: $_____/$_____ (STATE EXCEPTIONS: IN, FL, KS, PR, NY, SC, VA)		Website:

PLEASE TELL US ABOUT YOURSELF

1. Name: (First/Middle Initial/Last/Designation) ☒ DDS ☐ DMD ☐ MD ☐ BDS — KARYNA SHULIAK
2. Social Security Number: [redacted]
3. Date of Birth: [redacted]

4. Mailing Address: 6100 Red Hook Quarter B3 (Street) ST THOMAS (City) USVI (State) 00802 (Zip Code)

5. Telephone Number: [redacted]
6. Fax Number: (_____)_____
7. E-mail Address: [redacted]

8. Years in Practice: 1
9. Dental School Attended: Columbia Dental School
10. Month/Year of Graduation: MAY 2015

11. Are you entering practice for the first time?..... ☑ Yes ☐ No
If "Yes", did you complete a residency?..... .. ☐ Yes ☑ No
Specialty: _____ Month/Year of Completion: _____

12. Business structure under which you practice (Check all that apply):
A. ☐ Employee ☐ Independent contractor ☐ Sole proprietor ☐ Incorporated ☐ Partnership ☒ L. L. C. ☐ L. L. P.
☐ Professional Association ☐ Professional Corporation ☐ Other (describe) _____

- Provide the name of the Legal Entity LSJ Dental LLC
- Do you desire shared or separate limit of liability to apply to this entity?
☒ Shared (limits are shared with you) ☐ Separate (entity has its own set of limits)

B. Besides yourself, list the names of all dentists who are partners/corporate officers for all legal entities: (If additional space is needed, please list on a separate sheet of paper). **(Note: All partners/ corporate officers must be insured by CNA)**

Name	Social Security No.	Name	Social Security No.

C. If you own your practice, please provide the number of the following who work for you:

	# of full-time	# of part-time
Employee dentists (other than yourself and/or partners/corporate officers)?..... (Attach separate application or proof of professional liability insurance)		
Independent Contractor dentists (Attach separate application or proof of professional liability insurance)		
All other employees (i.e., hygienist, dental assistants, technicians, etc.)		
Total	0	0

D. Do you work for another dentist as an independent contractor dentist? ☐Yes ☒No
If "Yes", please provide the name of the employer/facility: _____

E. Do you work for another dentist as an employee dentist? ☐Yes ☒No
If "Yes", please provide the name of the employer/facility: _____

F. Do you share dental facilities with other dentists who are not covered under this policy? ☐Yes ☒No
If "Yes", attach proof of professional liability insurance for the other dentists

13. Practice Addresses and Percentage of Practice at Each Address (**Total of Percentages Must Equal 100%**):
Primary

1) _____
Street | City | County | State | Zip Code | %

2) _____
Street | City | County | State | Zip Code | %

3) _____
Street | City | County | State | Zip Code | %

14. Are you a member of your state dental association or society? ☐Yes ☐No

15. How many hours per week do you practice (include lab work, patient visitation and consultation)? 40
If 20 hours or less, please complete a Part-time Supplement

16. Are you currently licensed to practice dentistry? ☐Yes ☐No
State(s): _____ License #(s): _____

17. Have you taken one of the following risk management seminars in the last 3 years? ☐Yes ☐No
☐ CNA (Evidence not required if you are a CNA insured) ☐ Hartford ☐ AAOMS ☐ AAO ☐ Princeton ☐ NYSDA
Date of Attendance ____/____/_____ If "**Yes**", provide evidence of attendance.

18. Indicate your Practice Specialty
☒ General Dentistry
☐ Endodontics
☐ Oral/Maxillofacial Surgery
☐ Oral Pathology
☐ Anesthesiology(Dental)-Conscious Sedation
☐ Oral Radiology
☐ Orthodontics
☐ Pediatric Dentistry
☐ Periodontics
☐ Prosthodontics
☐ Public Health
☐ Full-time Faculty-Non-Intramural
☐ Anesthesiology(Dental)-General Anesthesia

19. Which of the following procedures are performed by you:
☐ Irreversible TMJ-Phase II (such as bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder)
☐ Implant Surgery
☐ "Sargenti", paste fill or similar endodontic techniques
☒ Extraction of Impacted teeth
☐ Implant Restoration
☐ Molar Endodontics on Permanent Teeth
☐ Sleep Apnea Therapy If "**Yes**", please indicate the following:
☐ I treat only after referral from physician ☐ I treat without physician referral ☐ I fabricate snore guard
☐ Weight Loss Therapy, including DDS System If "**Yes**", please indicate the following:
☐ I treat only after referral from physician ☐ I treat without physician referral DDS System Certification Date: _____
☐ Cosmetic dermal procedures (including Botox, restinor hyaluronic acid products, collagen injections, dermabrasions, etc.)
If "**Yes**", please provide an explanation on a separate sheet of paper.
☐ Consulting Services (Rendering advice or recommendations, practice management consulting, expert witness testimony)
If "**Yes**", do you desire coverage? ☐ Yes ☐ No
☐ None

20. A. Have you ever had a change in the status of your hospital privileges? ☐ Yes ☒ No
If "**Yes**", provide details on a separate sheet of paper.

B. Has any governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions? ☐ Yes ☒ No
If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

C. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency? ☐ Yes ☒ No
If "**Yes**", provide a copy of the board transcript or other documentation, including resolution.

D. Have you been convicted of any criminal charges? ☐ Yes ☒ No
If "**Yes**", provide details from investigating agency.

E. Have you ever been treated for alcoholism, drug addiction, mental illness or physical impairment? ☐ Yes ☒ No
If "**Yes**", provide a letter from treating physician with complete details.

PLEASE TELL US ABOUT YOUR USE OF ANESTHETICS AND ANALGESIA

Please be sure to read and answer all parts very carefully. For purposes of these questions, the following definitions of **Anxiety Reduction, Conscious Sedation** and **General Anesthesia/Deep Sedation** are provided:

- **Anxiety Reduction** is defined as "the use of nitrous oxide/oxygen and/or oral premedication used in an accepted therapeutic dose to reduce anxiety."
- **Conscious sedation** is defined as: "A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof."
- **General Anesthesia and Deep Sedation** are defined as: "A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposely to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof."

21. A. Is your practice limited to the use of local anesthesia, oral medication and/or nitrous oxide? ☒ Yes ☐ No

B. Are you treating patients who are under conscious sedation? ☒ Yes ☐ No

C. Are you treating patients who are under general anesthesia / deep sedation? ☐ Yes ☒ No
If **"Yes"**, where are the procedures performed? ☐ In your office ☐ In a hospital or surgical center
If **"In Your Office"**, who administers the anesthesia? ☐ You ☐ Another Dentist, Anesthesiologist or CRNA

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

Do not complete questions 22 through 29 if you are a current PPP insured.

22. Are you now, or have you ever, practiced without professional liability insurance? ☐ Yes ☐ No
If **"Yes"**, provide dates and reason:

23. Have you ever had any professional liability insurance refused, cancelled or non-renewed? ☐ Yes ☐ No
If **"Yes"**, provide dates and reason: **(NOT APPLICABLE FOR MO)**

24. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
If **"Yes"**, please complete Supplemental Claim form.

25. Are you currently aware of any situation that could lead to a malpractice suit against you? ☐ Yes ☐ No
If **"Yes"**, please complete Supplemental Claim form.

26. List prior carrier(s) for the past **three (3)** years. If none, state "None."

Insurer	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability

27. Are you applying for prior acts coverage from CNA? ☐ Yes ☐ No
If **"Yes"**, please attach a copy of your last declaration page (face sheet).

28. Prior Acts date (Retroactive date) used by your previous carrier_____

29. Was an extended reporting endorsement (tail) purchased form your previous carrier? ☐ Yes ☐ No

PLEASE TELL US ABOUT YOUR PREMISES/OPERATIONS

30. If your equipment lease or rental requires you to name the equipment lessor as an additional insured, please provide the name and address of the lessor as it appears on the lease or rental agreement:
N/A

LSJE LLC 6100 Red Hook Quarter B3 St Thomas USVI 00802

31. If your building lease requires the building owner to be included as an additional insured for the portion of the premises leased to you, please list the Lessor's name and address as it appears on your lease:

32. Have you had any general liability losses in the past **three (3)** years?..... ..☐ Yes ☒ No
If "**Yes**", provide date(s) of loss and detail(s).

33. Do you want ERISA Fiduciary Liability coverage ($100,000 Limit of Liability)?..... ..☐ Yes ☒ No
Coverage is recommended if you sponsor any Employee Benefit Plan. Coverage is written on a Claims-made basis.

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

I understand that my Professional Liability Coverage will be written on a "Claims-Made form" and acknowledge that this coverage will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" coverage will not provide insurance coverage for claims which occurred prior to the "Prior Acts Date" of my policy.

I understand that, should my "Claims-Made" policy with this insurance carrier ever be cancelled or non-renewed, or I decide to terminate it for any other reasons, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to the insurance company before the date of the policy termination, I will be able to purchase additional insurance coverage.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

Signature in full: _____ Date 10/26/2015

REMINDER:

Please attach a sample of your letterhead and a copy of all of your dental practice "Yellow Pages" advertising, if any, to this application.

RETURN TO:

State Administrator Name:

_____

_____

Address:

_____

City: State: Zip Code:

_____

Phone #: (_____)_____

Agent's License Number: _____