



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:

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



d) have you been practicing in the UK for the last 2 years?

Yes No

If no, please state where you have been working:

Text input area for where you have been working.

e) your GDC Registration Number:

Text input box for GDC Registration Number.

f) the date of original GDC Registration:

Text input box with placeholder MM / YY for date of original GDC Registration.

g) your current GDC registration status?

Text input box for current GDC registration status.

h) whether you are a member of any professional association(s):

Yes No

If yes, please provide full details:

Text input area for details of professional association(s).

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 Locum?

Yes No

If yes, please state how many practices you cover?

Text input box for number of practices covered.

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

Text input box for number of sessions per week.

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

NHS

Text input box with % symbol for NHS patient split.

Private

Text input box with % symbol for Private patient split.

3.5 Please advise your total annual gross income before deductions:

Text input box with £ symbol for total annual gross income.

3.6 Approximately how much of your practice relates to paediatric work?

Text input box with % symbol for paediatric work percentage.



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

The total of all activities listed should equal 100%:

General Dentistry:	<input style="width: 50px;" type="text" value="%"/>	Oral and Maxillofacial Surgery:	<input style="width: 50px;" type="text" value="%"/>
Orthodontics:	<input style="width: 50px;" type="text" value="%"/>	Implants:	<input style="width: 50px;" type="text" value="%"/>
Endodontics:	<input style="width: 50px;" type="text" value="%"/>	Legal Report Writing:	<input style="width: 50px;" type="text" value="%"/>
Periodontal:	<input style="width: 50px;" type="text" value="%"/>	Other: <i>please specify below</i>	<input style="width: 50px;" type="text" value="%"/>
Total:			<input style="width: 50px;" type="text" value="100%"/>

3.8 If you undertake Level 1-2 please give details of the number of procedures per year

LEVEL 1 – Surgery involving intral-oral tissues, teeth and tooth carrying bones, including the following procedures:

a) Exdontia e.g. wisdom teeth removal, apicectomies	<input style="width: 100px;" type="text"/>
b) Minor cyst removal from hard or soft tissue	<input style="width: 100px;" type="text"/>
c) Placement of dental implants (ex. Sinus lifts and bone augmentation which involve the floor of the sinus, or extra bone harvesting, all of which are regarded as maxillofacial procedures)	<input style="width: 100px;" type="text"/>

LEVEL 2 – Surgery involving intra-oral tissues, teeth and tooth carrying bones, including LEVEL 1 procedures as above, but also including:

a) Sinus lifts and bone augmentation which involve the floor or the nose or sinus, or extra bone harvesting.	<input style="width: 100px;" type="text"/>
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3.9 Do you undertake any Oral/Maxillofacial surgery other than level 1 or 2, as defined below? Yes No

If yes, please provide details:

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

General Anaesthetic	<input style="width: 50px;" type="text" value="%"/>	Inhalation Sedation	<input style="width: 50px;" type="text" value="%"/>
IV Sedation	<input style="width: 50px;" type="text" value="%"/>		



3.11 Do you provide any cosmetic procedures where the primary objective is to improve cosmetic appearance?

Yes No

If yes, please provide details on which procedures below:

a) Teeth whitening

Yes No

b) Temporary dermal fillers (e.g. Restylane)

Yes No

c) Botox

Yes No

d) Other – *please specify below*

Yes No

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

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3.13 Do you subscribe or belong to any cosmetic/beauty association, if so please state:

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3.14 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
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

3.15 Please state whether you plan to retire during the next 5 years:

Yes No

If yes please provide the anticipated date:

MM / YY



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 the 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 insure 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:	_____		

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:

A large, empty rectangular box with a thin black border, intended for providing additional information.