**DentistCare**[SM]

**Premium Indication Form** • For UnifiedSmiles Member

When complete, email or fax to Micaela Miles:
E - Micaelam@huttenlochergroup.com
F - (248)681-0362

Name: _____

Practice Name: _____

Street Address: _____ County: _____

City, State, ZIP: _____

Office Phone: _____ Cell Phone: _____

Fax: _____ Email: _____

Best time to contact you: _____

1. Dental Specialty: _____
2. Number of hours worked per week: _____
3. Do you administer: Local Anesthesia and Nitrous Oxide ☐ Oral Premedication ☐
   IV/IM Sedation ☐ Conscious Sedation ☐ General Anesthesia ☐
4. Do you perform:
   Oral Surgery: Minor ☐ Major ☐
   Surgical placement of implants ☐ Multi-rooted Endodontics ☐
   Extractions: Partial Bony Impactions ☐ Third Molars ☐ Full Impactions ☐
   Soft Tissue Surgery ☐ Bone Grafts ☐
5. Do you provide elective facial cosmetic procedures, Botox, collagen injections, or other dermal fillers for cosmetic purposes in your practice? Yes ☐ No ☐
6. Desired type of coverage:
   Claims-Made ☐ Retroactive Date: _____
   Occurrence (where available) ☐
7. Desired level of coverage:
   Primary Coverage Limits: _____
   Excess Coverage Limits (where available): _____
8. Current professional liability carrier: _____ Policy exp. date: _____
9. Dental school: _____ Year graduated: _____
10. Any professional liability claims or board or license action in the last 10 years:
    Yes ☐ No ☐
    *If yes, a loss run and additional information may be required.*
11. Current membership(s): ADA ☐ AGD Member ☐ AGD Fellowship ☐ AGD Mastership ☐
12. Is your practice a partnership, corporation or LLC? Yes ☐ No ☐
    If yes, what is the name? _____ # of Dentists: _____

*This information is for a premium indication only. A fully completed submission, including an application, is required for a coverage determination.*

Please return this completed form to your insurance agent or broker.