PROFESSIONAL INSURANCE EXCHANGE MUTUAL, INC.

445 East 4500 South #130, Salt Lake City, UT 84107 801-262-0200 info@pieutah.org

PROFESSIONAL LIABILITY INSURANCE APPLICATION

Name_____ Date of Birth_____
Preferred Mailing Address: Home Telephone_____
_____ Office Telephone_____
_____ Cell Phone_____
_____ e-mail address_____

COVERAGES	LIMITS OF LIABILITY		DATE COVERAGE to be EFFECTIVE
Professional Liability Claims Made Policy	**Each Claim** ***$1,000,000***	**Annual Aggregate** ***$3,000,000***	_____ **START DATE**

1. Professional School Attended_____ Degree_____ Year Graduated_____
(If foreign dental school graduate are you certified by the Educational Council for Dental School Graduates? Yes___ No_____
Year certified_____

2. Type of practice or certified specialty: ___General Practitioner ___Endodontist
___Oral Pathologist ___Pediatric Dentist
___Periodontist ___Orthodontist
___Prosthodontist ___Other_____

3. Served residency/internship at_____ Year Completed_____

4. Name all places where you have practiced your profession since graduation:
In_____ During Years_____
In_____ During Years_____

5. List name and address of any prior malpractice insurance carrier:_____
_____
You will need to furnish a Claims/Loss Run from each prior carrier. This document must state the carrier name, specific years of prior coverage and any claims history you may have.

6. Specify name and location of hospitals/surgical centers in which you hold staff or courtesy privileges:
_____

7. What professional organizations are you a member of? ___ADA; ___UDA; ___AGD
___ Other_____

8. Do or will you practice as: Solo Practioner?_____ Partner or Associate in Group Practice?_____
Name of partners or members of corporation or professional association (if applicable): _____
_____
Name of Practice:_____
Address of Practice:_____

9. Are you employed full time by the Federal Government or currently engaged in military service? Yes___No_____

10. Do you own or plan to own/operate a training facility for dental assistants or auxiliaries? Yes___No_____

11. Has any hospital ever restricted or revoked privileges or put you under probation? Yes___No_____

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12. Have you ever been denied a dental license or been denied certification by a specialty board? Yes___No____
13. Have you had any hearings or investigations before the Department of Occupational and Professional Licensing in Utah or before the Dental Board of any other State? Yes___No____
14. Has your dental license ever been suspended, revoked, or voluntarily surrendered, or has probation on your license ever been imposed in any state where you have been licensed? Yes___No___
15. Has your state license to prescribe or DEA Number ever been suspended, revoked, or voluntarily surrendered? Yes___No____
16. Have you ever been convicted or pled guilty to a felony crime? Yes___No____
17. Has any dental malpractice claim ever been made against you? Yes___No____
18. Has any malpractice insurance carrier ever cancelled or refused coverage? Yes___No____
19. Are you now or have you ever voluntarily or involuntarily participated in a diversion program or rehabilitation program for drug or alcohol abuse? Yes___No____
20. Have you been investigated by a state association or component society peer review committee? Yes___No____
21. Have there been any serious or life-threatening incidents in your practice? Yes___No____
    If so, explain:_____

For questions 11-20 above, please describe any "Yes" answers fully:_____

_____

_____

22. Do you plan on having your dental hygienist(s) give local anesthetics? Yes___No____
    If yes, does he/she have her own coverage? Yes___No____
    If not, you will need to purchase the PIE "H Rider." All dentists in a group or partnership, etc, including associates, must obtain this H-Rider to avoid coverage gaps.
23. Utah Dental License Number_____ Anesthesia Class_____ Expiration Date_____
24. DEA Number:_____ Expiration Date_____
25. Check if you do any of the following procedures and FILL OUT ANESTHESIA FLOW CHART on Page 4:

A. ____ Nitrous Oxide Analgesia
B.____ In-office IV sedation provided by other professional
C.____ IV or General Anesthesia provided by other professional in hospital/other setting
D.____ In-office IV/IM sedation provided by you personally
E.____ Oral/enteral conscious sedation with or without N_2O and one sedative drug
F. ____Oral/enteral conscious sedation with or without N_2O and more than one sedative drug

26 Are you currently CPR Certified? Yes____No____ Up to date on required CE Hours? Yes___No____
27. Have you established emergency procedures, personnel and equipment to cope with patient emergencies, such as cardiac arrest, anaphylactic shock, etc.? Yes___No____
28. Answer each of the following with regard to your current office procedures:
    If you are starting a new practice, answer each question as you intend to practice.
    A. Do you keep a record of pertinent patient phone calls regarding treatment? Yes___No____
    B. Do you document and verify all patient referrals to specialists? Yes___No____
    C Do you plan to have patients sign a Consent to Proceed plus detailed Consent forms for specific procedures? PIE will furnish example forms. Yes___No____
29. Are you affiliated with any Dental School Faculty? Yes___No____
    If Yes, list name of Dental School:_____
30. Approximate hours/week you plan to practice:_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT ANY FALSE STATEMENTS OR UNLAWFUL ACTS WILL RENDER MY COVERAGE NULL AND VOID.

Signing this application does not bind the Company to provide insurance but it is agreed that this form shall be the basis of the contract should this policy be issued. If accepted for insurance, I authorize PIE to release personally identifiable financial information as applicable to affiliates and non-affiliates disclosed on the PIE Privacy Policy statement for purposes of reinsurance premium calculation, etc.

Signature_____Date_____

SUPPLEMENTAL QUESTIONS FOR DENTISTS WHO CARRY CLASS C or CLASS D LICENSES

YOU MUST CARRY PIE CLASS II COVERAGE IF YOU PROVIDE ENTERAL OR PARENTERAL SEDATION

1. Please list your drug(s) of choice and standard dosage regimen:_____

_____

	YES	NO
2. Are you using the following recommended monitoring device, etc?		
Pulse oximeter	_____	_____
List Serial No. and Brand Name_____		
Current emergency drugs	_____	_____
Positive pressure oxygen	_____	_____
3. Do all patients who undergo oral conscious sedation sign a written informed consent specific for oral sedation that has been reviewed and approved by PIE?	_____	_____
4. Do you have patients complete a health history form within one week of a scheduled procedure that expresses no contraindications to the use of oral sedative agents?	_____	_____
5. Do you keep a supply of reversal drugs (e.g. Romazicon) available?	_____	_____
6. Do you log vital signs at specific intervals during the procedure?	_____	_____
7. Do you limit the oral sedation technique to patients over 18 and under 60 years old, or have you taken an advanced course on sedation for children and elderly pts?	_____	_____

8. When did you originally take an introductory course in anxiolytic drugs and oral sedation?_____

Furnish copy of Course Attendance Certificate.

PIE requires you to take a refresher course every three years.

SUPPLEMENTAL QUESTIONS FOR DENTISTS WHO PERFORM THEIR OWN IV/IM/PARENTERAL SEDATION

NOTICE: YOU ARE NOT COVERED TO USE PROPOFOL AS PART OF YOUR IN-OFFICE IV SEDATION REGIMEN.

	YES	NO
1. Are you in compliance with all equipment and monitoring requirements as specified in R156-69-601 of the Utah Practice Act, including Pulse oximetry	_____	_____
Current emergency drugs	_____	_____
Positive pressure oxygen	_____	_____
2. Do all patients who undergo parenteral sedation sign an informed consent form specific for parenteral sedation that has been reviewed and approved by PIE?	_____	_____
3. Do you utilize a third person (besides you and your dental assistant) whose sole duty is to monitor the patient and record pertinent data during the procedure?	_____	_____

4. How many parenteral sedation cases do you expect to perform per month? _____

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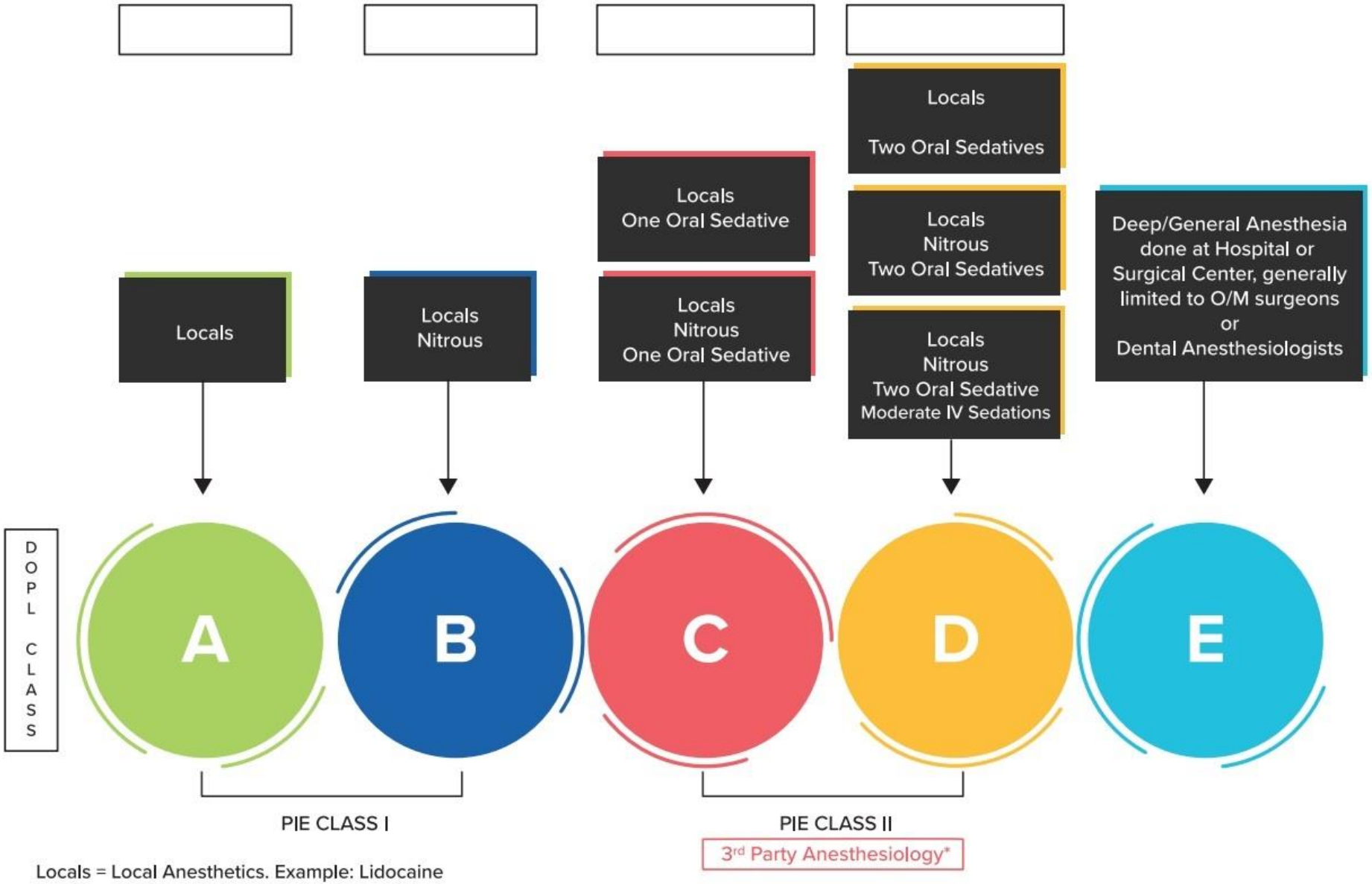
Name_____ Signature_____ Date_____

Dentists, please initial in the blank square indicating the deepest level of anesthesia YOU (not an anesthesiologist) will administer this year. See that your DOPL license matches flow chart, if not, please update your license with DOPL before renewal.



Locals = Local Anesthetics. Example: Lidocaine
Nitrous = Nitrous Oxide nasal hood
Oral Sedative Drug = A prescribed oral sedative which is active at time of treatment. Examples: Triazolam, benzodiapenes, Demerol
Moderate I.V. Sedation = Propofol NOT included, but all other sedative drugs used to achieve moderate sedation
Deep/General Anesthesia = extensive anesthesia training during Oral Surgery, Medical, or Dental anesthesia residencies - not performed in a dental office
* Dentists who use a 3rd party to perform in-office sedation must carry PIE class II coverage.

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SUPPLEMENTAL QUESTIONS FOR RECENT GRADUATES

Please answer the following questions if you were graduated from dental school within five years of submitting this application:

1. Did you ever fail any portion of your National Board Examinations? Yes___No___
   If yes, list portion(s) failed and reason for failure

2. Did you fail any course, clinical or didactic, during dental school? Yes___No___
   If yes, state course and date of remedial coursework, including grade:
   Course Date Grade
   _____
   _____

3. Did you have to repeat any of the above courses more than once? Yes___No___
   If yes, state course and reasons remedial coursework had to be repeated._____
   _____

4. Did you graduate on time, i.e. on the date that your dental school class was scheduled to graduate? Yes___No___
   If no, state reason that your graduation was delayed:_____
   _____

5. List Regional Licensing Board Passed:_____
   Date Passed:_____

6. List State Licensing Board Examinations Passed:_____
   Date Passed:_____

7. Did you pass the above state or regional examinations on your first attempt? Yes___No___

8. Did you ever fail a state or Regional Licensing Board Examination? Yes___No___
   If yes, list Examination(s) failed, date(s), and section(s) failed:
   Examination (state or regional) Date failed Section Failed Reason
   _____
   _____

9. List any honors or recognitions received during dental school:_____
_____

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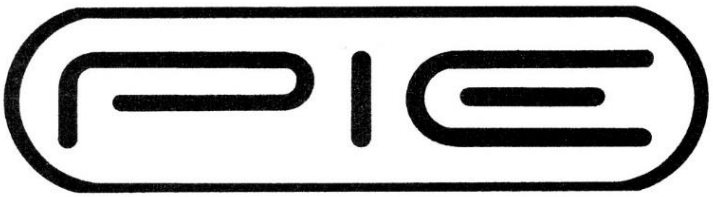
Signature_____ Date_____



PROFESSIONAL
INSURANCE EXCHANGE
MUTUAL, INC.

SUBSCRIBER'S AGREEMENT

WHEREAS, the undersigned is a resident of the State of Utah and is licensed to practice dentistry in the State of Utah;

WHEREAS, the undersigned desires to enter into membership among other subscribers of a mutual insurance company providing indemnity against professional liability, said mutual insurance Company shall be known as Professional Insurance Exchange Mutual, Inc. (PIE)

NOW THEREFORE, the undersigned agrees with PIE and the other subscribers

1. To join with the other subscribers insuring against losses and to be subject to such terms and conditions and limits of liability as set forth in the policy. The terms, conditions and limits of liability of the policy shall be specified by the Company in compliance with sound and accepted insurance practices and reasonable standards established by the Subscribers' liability set forth herein.

2. To make all premium payments and applicable surcharge payments when due for policies of insurance issued in accordance with schedules of rates prepared from time to time by the Company in compliance with sound and accepted insurance practices and reasonable standards established by the Company's Board of Directors and approved by the Commissioner of Insurance of the state of Utah.

3. To abide by such rules and regulations of the Company as stated in the Bylaws or adopted by the Company's Board of Directors from time to time.

4. To release all past and current information pertaining to underwriting and claims by the undersigned's prior insurers or their agents.

5. To the appointment of Richard C. Engar, D.D.S. as Chief Executive Officer (CEO) to administer the day-to-day operations of the Company and oversee underwriting of potential new subscribers.

6. To allow the Subscribers' Board of Directors to supervise and control the activities of the Company.

7. To authorize PIE to release personally identifiable financial information as applicable to affiliates and non-affiliates disclosed on the PIE Privacy Policies statement for purposes of reinsurance premium calculation, etc.

IT IS FURTHER AGREED that the subscribers' Board of Directors shall consist of nine members elected at the annual meeting of subscribers by the subscribers exercising one vote each. Board members shall be elected for terms of three years each. Terms shall be staggered such that three positions are due for election each year. Not less than eight such Board members shall be subscribers or members of PIE. The Subscribers' Board of Directors shall supervise the finances of Professional Insurance Exchange Mutual, Inc. and supervise its operations to assure conformity with this Agreement and the Bylaws of the Company, procure examinations or audits of the accounts and records of Professional Insurance Exchange Mutual, Inc. and shall have such additional powers and functions as may be conferred from time to time by majority vote of the subscribers.

Signed at_____, Utah, this_____ day of_____, 20_____.

_____
(Signature)

Please type or print your name and residence address:

Name_____

Street_____

City_____State_____Zip_____