ASPEN AMERICAN INSURANCE COMPANY

BROKERING AGENT'S REGISTER No. _____
[Florida Applicant's Only]

PROFESSIONAL PROTECTOR PLAN FOR DENTISTS | PPP

The Professional Protector Plan®
Oral and Maxillofacial Surgeon Questionnaire - Florida

ASPEN AMERICAN INSURANCE COMPANY
(A stock insurance company)
Administrative Offices: 590 Madison Avenue, 7th Floor, New York, NY 10022

DEPENDING ON THE COVERAGE YOU ELECT, THE POLICY YOU ARE APPLYING FOR MAY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR DURING AN APPLICABLE EXTENDED REPORTING PERIOD.

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.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional information may be required upon review of the application.

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

Name:_____ **Policy Number:**_____

Effective or Renewal Date:_____ **State:**_____

PART A: ANESTHESIA

1. Do you use or have:

A. Oral / Maxillofacial Anesthesia Permit?..... ☐ Yes ☐ No

If **"Yes"**: Permit #:_____ State:_____ Expiration Date:_____/_____/_____

B. Continual blood pressure monitoring either by use of:

I. An electronic monitor?..... ☐ Yes ☐ No

II. A standard blood pressure cuff with checks at appropriate intervals?..... ☐ Yes ☐ No

C. Continuous electrocardiographic display (EKG)?..... ☐ Yes ☐ No

D. Precordial, esophageal, or pretracheal stethoscope?..... ☐ Yes ☐ No

E. Pulse oximeter?..... ☐ Yes ☐ No

If **"Yes"**, does it have an alarm system?..... ☐ Yes ☐ No

F. Any other devices (explain)?_____

2. What type of anesthesia do you perform?

A. Local including nitrous oxide: _____%

B. Conscious: _____%

C. General: _____%

3. What type of general anesthesia follow-up procedures do you use?_____

_____

_____

4. Are you Advanced Cardiac Life Support (ACLS) certified?..... ☐ Yes ☐ No

5. Are your staff members Basic Cardiac Life Support (BCLS) certified?..... ☐ Yes ☐ No

6. What type of emergency equipment do you have on hand? Please describe:_____

_____

_____

7. Do you perform conscious sedation, deep sedation, or general anesthesia on patients whom you are ***not*** performing dental or surgical treatment?..... ☐ Yes ☐ No

If **"Yes"**, please describe the volume and circumstances:_____

_____

PART B: DO YOU PERFORM ANY OF THE FOLLOWING PROCEDURES?

		# of Procedures Per Year	Elective	Non-Elective *
1. Rhinoplasty	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
2. Blepharoplasty	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
3. Liposuction above the neck	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
4. Liposuction below the neck	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
5. Hair transplants	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
6. Blepharopigmentation	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
7. Facelifts / Brow lifts / Forehead lifts	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
8. Botox injections	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
9. Filler injections	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
10. Genioplasty	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
11. Wrinkle remover	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
12. Fat transplantation	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
13. Scalp reductions	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
14. Tattooing	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
15. Tattoo removal	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
16. Collagen injections	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
17. Silicone injections	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
18. Laser resurfacing or chemical peels	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
19. Malar augmentation	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
20. Superficial varicosities by sclerosing solution chemical peels	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
21. Osseointegrated implant placement	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
22. Subperiosteal or blade implant replacement	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
23. Microsurgery	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
24. Nerve repair	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
25. TMJ arthroscopy	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
26. TMJ surgery	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
27. Cosmetic surgery below the neck	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

List Procedures:_____			
28. Laser surgery ☐ Yes ☐ No List Procedures:_____		☐ Yes ☐ No	☐ Yes ☐ No
29. Do you perform experimental surgery? ☐ Yes ☐ No Describe:_____		☐ Yes ☐ No	☐ Yes ☐ No

*** NON-ELECTIVE PROCEDURES ARE DIRECTLY RELATED TO AND PART OF TREATMENT FOR DENTAL CONDITIONS.**

PART C: EDUCATION AND TRAINING INFORMATION

1. Please include all pertinent training. If preferred, you may attach your CV.

Name of Institution	Dates (MM/YY) From	To	Specialty and/or Degree
Dental School:			
	____/____	____/____	
Medical School:			
	____/____	____/____	
Internship:			
	____/____	____/____	
Residency I:			
	____/____	____/____	
Residency II:			
	____/____	____/____	
Fellowship:			
	____/____	____/____	

2. Are you board eligible? ☐ Yes ☐ No Board certified? ☐ Yes ☐ No

If **board certified**, date of certification:____/____/____

3. Please indicate all of your professional degrees:

☐ DDS ☐ DMD ☐ MD ☐ BS ☐ Other:_____

4. List any specialty boards, associations, or professional organizations of which you are a member:_____

PART D: PATTERN OF PRACTICE

1. Do you take a medical history of the patient before the procedure is performed?.....	☐ Yes ☐ No
2. Is ***written*** informed consent obtained on each procedure?.....	☐ Yes ☐ No
3. Is ***oral*** informed consent obtained on each procedure and documented in the patient's record?.....	☐ Yes ☐ No

4. Surgery is performed in:

A. The Office: _____%

B. A Surgicenter _____%

C. A Hospital _____%

D. Other:_____ _____%
(Please specify) 100%

PART D: PATTERN OF PRACTICE – Continued

5. Do you transfer or delegate post-operative care to others besides yourself?..... ☐ Yes ☐ No

If **"Yes"**, please explain:_____

_____

_____

6. Is major surgery ever performed outside the hospital?..... ☐ Yes ☐ No

For example, orthognathic surgery, surgical intervention of Ludwig's angina or panfacial abscess, treatment of facial fractures.

If **"Yes"**, please explain:_____

_____

_____

7. Please name the hospitals where you have privileges to perform Oral / Maxillofacial surgery:_____

_____

_____

8. Are you on the active teaching facility at a training institution?..... ☐ Yes ☐ No

If **"Yes"**, please provide the names of the institutions, the dates of the faculty appointment, and a description of your duties:_____

_____

_____

9. Do you practice itinerant surgery?..... ☐ Yes ☐ No

If **"Yes"**, please describe:_____

_____

_____

AUTHORIZATION

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize AAIC to release the information on this application and associated underwriting information.

FRAUD NOTICE

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____

Signature in full Date

_____

Agent's Signature Date

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

This application is in compliance with Section 626.752, Florida Statutes. A copy has been furnished to the applicant or insured and coverage is:
[ ] Bound Effective (time) (date); [ ] Not Bound.

BROKER'S SIGNATURE:
Florida requires that we have the Name and Address of your (Applicant's) Authorized Agent or Broker.

Signature of Authorized Agent or Broker: _____

Name of Authorized Agent Broker: _____

Address:_____

License Identification Number: _____