

# Dental Shield

## Proposal Form

*Please complete, sign and return together with the attachments to:*

*Tom Hester  
Lockton Affinity  
The St Botolph Building  
138 Houndsditch  
London EC3A 7AG*

*Tel: 0845 050 0261  
Fax: 020 7933 0739*



## IMPORTANT NOTICE REGARDING COMPLETION OF THIS PROPOSAL FORM

### 1. Disclosure

- Any “material fact” must be disclosed to Insurers.
- A “material fact” is any information which may affect the judgement of an Insurer in assessing a risk.
- Any “material change” must be disclosed to Insurers.
- A “material change” is any information which may affect the judgement of an Insurer or their perception of risk and exposure that has not previously been disclosed as a material fact.

**(If you are unsure whether a fact or change is material or not, you should disclose it.)**

**Failure to provide all “material facts” and/or notify all “material changes” may cause the contract of insurance to be void and may result in Insurers repudiating liability entirely.**

### 2. Presentation

- This Proposal Form must be completed in ink by the insured.
- **All** questions must be answered.
- If there is insufficient space to provide answers, additional information should be provided on separate sheets (ideally on Company headed notepaper), clearly identifiable as forming part of the proposal form.
- Where available brochures, standard contract conditions, conditions, agreements and letters of appointment should be provided.

**Failure to present Insurers with information in an appropriate manner may adversely influence the ability of Insurers to offer terms.**

### 3. Guidance

- If in doubt as to the meaning of any question contained within this proposal form or the issues raised in (1) or (2) above, please contact an Account Executive at Lockton.

### 4 DATA PROTECTION

By signing this proposal form you consent to Lockton using the information we may hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities. In the course of performing our obligation to you, this information may be disclosed to agents and service providers appointed by us, insurers, (which includes their re-insurers, legal advisers, loss adjusters or agents). Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and, where appropriate, in compliance with the relevant Data Protection legislation. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

**Additional information should be provided on separate sheets (ideally on Company headed notepaper), clearly identifiable as forming part of the proposal form.**

From time to time, we may disclose personal information (other than sensitive personal data) to other Lockton Companies. We or they may use that information to advise you of our services which may be of interest to you. If you would prefer not to receive information, please contact an Account Executive at Lockton.

## **SECTION A – YOUR DETAILS**

Please provide the following details:

Title:	Forename:	Surname:
Date of Birth:	Nationality:	Gender:
Home Address:	Practice Address:	
Postcode:	Postcode:	
Home No:	Mobile No:	Work No:
Contact email address:		
Registration Body:	Registration Number:	
Registration Date:	Registration Type: Full / Limited / Provisional:	

## **SECTION B – ACADEMIC DETAILS**

Please provide the following details:

Country of Qualification:	Year of Qualification:
Dental School:	
Post Graduate Qualifications / Training:	

## **SECTION C – PRACTICE DETAILS**

Please provide the following details:

<b>1. Type of Practice:</b> A Practice Owner / Provider / Contractor	Yes / No
Employed	Yes / No
Self Employed / Associate / Performer	Yes / No
	Yes / No
<b>2. Do you practice:</b> Full Time	Yes / No
If “no” please state the number of sessions worked <i>per week</i>	No of Sessions:
<b>3. What is the split of patients between NHS and Private?</b>	NHS: % Private: %
<b>4. What is your</b> Gross Fee Income (before expenses) if self employed?	.....
Gross Income (before tax and NI) if employed?	.....

**SECTION D – ACTIVITIES**

Please provide the following details:

<b>1. Please indicate the time devoted to each of the following activities:</b>																			
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;"><b>Activity</b></td> <td style="padding: 2px;"><b>Percentage of Time</b></td> </tr> <tr> <td style="padding: 2px;">General Dental Practice:</td> <td style="padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">General Anaesthetic</td> <td style="padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">Implantology:</td> <td style="padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">IV Sedation:</td> <td style="padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">Oral and Maxillofacial Surgery:</td> <td style="padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">Orthodontics:</td> <td style="padding: 2px;">%</td> </tr> <tr> <td style="padding: 2px;">Surgical Periodontal Treatment:</td> <td style="padding: 2px;">%</td> </tr> </table>	<b>Activity</b>	<b>Percentage of Time</b>	General Dental Practice:	%	General Anaesthetic	%	Implantology:	%	IV Sedation:	%	Oral and Maxillofacial Surgery:	%	Orthodontics:	%	Surgical Periodontal Treatment:	%			
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<b>2. Do you undertake any Oral and Maxillofacial Surgery? If “yes” please advise which you undertake and how many hours per week you are dedicated to such procedures:</b>		<b>Yes/No</b>	<b>How many Hour per week</b>																
(i)Exodontia e.g. wisdom teeth removal, apicectomies Minor Cyst Removal from hard or soft tissue Placement of dental implants (excluding sinus lifts and bone augmentation which involved the floor of the sinus, or extra bone harvesting, all of which are regarded as maxillofacial procedures) Minor pre-prosthetic surgery		Yes/No Yes/No Yes/No																	
(ii)Excision of maxilla. Extra oral procedures to face, head and neck including partial thyroidectomy Facial cosmetic surgery (including face lifts, dermabrasion, otoplasty, blepharoplasty and liposuction Hemimaxillectomy for malignancy. Neck surgery including block dissection of cervical lymph nodes Open reduction of zygomatic complex fracture Osteotomies (maxilla and/or mandible). Prosthetic replacement of temporomandibular joints including arthroplasty. Reconstruction with axial and micro-vascular flaps. Rhinoplasty (other than immediate trauma aftercare). Surgical treatment of thyroid and parathyroid glands. Surgery involving the orbital complex.		Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No																	
<b>3. Are you involved in any of the following cosmetic procedures, where the primary objective is to improve cosmetic appearance? If “yes” please advise below.</b>		Yes / No																	
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;"><b>Procedure</b></td> <td style="padding: 2px;"></td> <td style="padding: 2px;"><b>Number of Hours and Income per Year</b></td> </tr> <tr> <td style="padding: 2px;">Botox</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">.....</td> </tr> <tr> <td style="padding: 2px;">Coallagen Fillers (Restylane)</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">.....</td> </tr> <tr> <td style="padding: 2px;">Facial Peels</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">.....</td> </tr> <tr> <td style="padding: 2px;">Other</td> <td style="padding: 2px;">Yes / No</td> <td style="padding: 2px;">.....</td> </tr> </table>	<b>Procedure</b>		<b>Number of Hours and Income per Year</b>	Botox	Yes / No	.....	Coallagen Fillers (Restylane)	Yes / No	.....	Facial Peels	Yes / No	.....	Other	Yes / No	.....				
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Coallagen Fillers (Restylane)	Yes / No	.....																	
Facial Peels	Yes / No	.....																	
Other	Yes / No	.....																	
(i) What training have you undertaken in relation to the cosmetic procedures being carried out?																			
(ii) Do subscribe or belong to any cosmetic Association, if so whom:																			
<b>4. Are you registered on any Specialist Register? If “yes” please provide full details:</b>		Yes / No																	
<b>5. Do you plan to retire in the next 5 years?</b>		Yes / No																	

## **SECTION E – GENERAL QUESTIONS**

**Please provide the following details:**

1. Are you aware if any complaints, claims or circumstances that have been brought or threatened against you, or any incident which could leave to such a complaint, claim or circumstance?	Yes / No
2. Are you aware of any circumstances, which could leave to disciplinary action of suspension from practice?	Yes / No
3. Are you aware of any circumstance, which could leave to an investigation, suspension, the imposition of conditions or restrictions on your registration or license to practise, or your removal from a professional register of your license, by the relevant registration body?	Yes / No
4. Have you ever been subject to any form of disciplinary action?	Yes / No
5. Have you ever had conditions to practice, been suspended from practice or dismissed from practice?	Yes / No
6. Have you ever been subject to any form of investigation by a registration body or equivalent in another country?	Yes / No
7. Have you ever been subject of an adverse finding by a registration body or equivalent in another country?	Yes / No
8. Have you ever been refused registration or license to practise or been erased from registration or has your license to practice removed by a registration body?	Yes / No
9. Have you ever had any restrictions or conditions imposed on your registration or licence to practice by a registration body?	Yes / No
10. Have you ever been subject of Dental Defence Organisations adverse member procedure?	Yes / No
11. Has any Dental Defence Organisation declined to offer you membership, terminate membership or refused to renew membership?	Yes / No
12. Has any insurance indemnity provided ever declined to insure you, imposed special terms, cancelled or refused to renew your insurance?	Yes / No
13. Have you ever been convicted of a criminal offence or received a formal police caution (not spent under the Rehabilitation Offenders Act 1974)?	Yes / No
14. Have you ever been declared bankrupt or subject to insolvency proceedings, or entered in to any voluntary arrangements with creditors?	Yes / No

**If you have answered “yes” to any of the above, please can you provide full details including the following information: \_**

**Date of incident/s**

**A summary of the events, inc all relevant details such as your involvement**

**What action you took, including any involvement from your indemnity provider**

**Information on any payments made on your behalf for either legal costs or indemnity payments**

## **SECTION F – RISK MANGEMENT**

**Please answer all questions**

**If the answer is “no” to any of the questions, please indicate the timescales by which you will be able to meet these risk standards.**

1. Do you have a complaints system and nominated complaints manager?	Yes/No
2. Do you have a reliable method for recording and passing on messages?	Yes/No
3. Do you have a reliable method for making sure that results of tests and investigations are received and communicated to patients?	Yes/No
4. Do you have the facility to offer patients a chaperone if they require one?	Yes/No
5. Do you have a system for reviewing repeat medication?	Yes/No
6. Is resuscitation equipment available and maintained in accordance with any guidelines and are all staff up to date with the use of this equipment?	Yes/No
7. Do all staff have job descriptions and contacts?	Yes/No
8. Do you have a procedure for reporting and recording significant events, including those with adverse outcomes?	Yes/No
9. If you use locums, are they properly inducted?	Yes/No
10. Do you have a Continuing Professional Development programme that meets the requirements of personal development?	Yes/No
11. Do all clinical staff in the practice fully understand the concept of consent?	Yes/No
12. Do you have a policy for managing difficult patients?	Yes/No
13. Does the practice have a system for ensuring that those patients taking medication requiring monitoring are identified and treated properly?	Yes/No
14. Do all the appropriate staff have Hepatitis B vaccinations and appropriate monitoring?	Yes/No

**SECTION G - INDEMNITY**

Please advise the following:

<b>1. Please advise the first day that cover is required:</b>		/	/	
<b>2. Please provide full details of previous cover – please include all since qualification</b>				
Insurer	Limit	Start Date	Limit of Indemnity	Excess
3. What is the amount of indemnity now required?				
4. Has prior cover been on a CLAIMS MADE basis? If “Yes” what are the retroactive dates:				
5. Has any proposal for similar insurance made on behalf of the proposers business, any predecessor of the business, or any Partner, Principal, Director even been declined or has such insurance ever been cancelled, renewal refused or had any special terms imposed (other than general market increases)? If “Yes” please provide details below.				

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**SECTION 4 – DECLARATION**

I declare that the statements and particulars contained in the proposal are true and that I/we have not mis-stated or suppressed any material facts.

I agree that this proposal together with any other information supplied by me/us shall form the basis of any contract of insurance effected thereon.

I undertake to inform Insurers of any material alteration to these facts occurring before completion of the contract of insurance. However, the duty to disclose material facts continues after the completion of the proposal form and throughout any period of insurance (and any extension thereto), upon which this proposal form was used as the basis of the contract of insurance.

Signing this proposal does not bind the proposer to complete this insurance.

Signature (please also print)

Date