

# Professional Liability Insurance Application—Jewell Professional Insurance



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## DENTAL HYGIENISTS AND DENTAL ASSISTANTS

NAME \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
CITY/TOWN \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ EMAIL \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

DENTAL HYGIENIST \_\_\_\_\_ DENTAL ASSISTANT \_\_\_\_\_  
EMPLOYED \_\_\_\_\_ SELF-EMPLOYED \_\_\_\_\_  
DESIRED EFFECTIVE DATE \_\_\_\_\_  
CT DR. LIC# \_\_\_\_\_  
GRADUATION YEAR \_\_\_\_\_  
SCHOOL ATTENDED \_\_\_\_\_  
EMPLOYER \_\_\_\_\_

COVERAGE SELECTION:	\$2,000,000 per incident	\$1,000,000 per incident
	\$4,000,000 aggregate	\$6,000,000 aggregate
HYGIENIST	\$80.00	\$68.00
ASSISTANT	\$80.00	\$68.00

Are you a member of any professional association(s)? \_\_\_\_\_  
Have you had Professional Liability Insurance before? Yes No If yes, carrier name \_\_\_\_\_  
Have you ever been cancelled, non-renewed or declined insurance? \_\_\_\_\_  
Have you ever had a claim? \_\_\_\_\_  
Are you currently aware of any facts or circumstances that you reasonably believe may lead to a suit/claim?  
Yes No

METHOD OF ANNUAL PAYMENT: MC VISA  
NAME ON CARD: \_\_\_\_\_ BILLING ADDRESS: \_\_\_\_\_  
CARD NO. \_\_\_\_\_ EXP. DATE \_\_\_\_ / \_\_\_\_ 3 DIG. SECURITY CODE # \_\_\_\_\_ DATE \_\_\_\_\_  
TEL. NO. ASSOCIATED WITH CARD: \_\_\_\_\_ SIGNATURE IN FULL: \_\_\_\_\_