Company Protection application
UK

Dental Protection

0800 046 9470 | member.help@dentalprotection.org | dentalprotection.org

Please complete all editable sections of this form electronically and return by email to the address above.

This form must be submitted by a ***Company Officer*** (Director or Company Secretary) of the ***Company***.

This application is for a claims-made membership which responds to claims made against the ***Company*** and notified to Dental Protection during the period of membership and arising from treatment provided on or after the agreed retroactive date.

Please complete a separate application for each ***Company***. For example, if you are applying for membership for three incorporated/ limited companies, three separate application forms would need to be submitted. The information provided will be used to assess risk, determine whether membership will be provided, and to set subscription fees and terms. As separate entities, each ***Company*** will be individually priced and hold separate membership agreements.

If during the last ten years, the ***Company*** has been the subject of significant change in scope of practice or structure (such as growth/ expansion or sale of practices), please contact our team on 0800 0469470 to discuss your needs.

Please ensure that:

1. You disclose all material facts and circumstances which you, your ***Management*** and those responsible for arranging this indemnity, know or ought to know following a reasonable search.
2. You take care and ensure that all information provided is correct, accurate and complete.
3. If you need to add any further information to any of the sections, please use the space provided at the end of the form, referencing the question or section it applies to.
4. All questions are answered fully, stating 'N/A', 'Nil' or 'None' when applicable.

Information you'll need to complete this form:

- Name and Dental Protection membership numbers of the Directors (at least one Director must be a Dental Protection member at the time of application and throughout the membership).
- Number of employed and contracted staff that work/ have in the past worked for the ***Company***, and the relevant ***FTE***.

Definitions used in this document:

"***FTE***" means full-time equivalent. A full-time staff member is deemed to work 40 hours per week. You may for example, have several staff members working part-time whose hours, when added together, equal one ***FTE***.

"***Management***" means Owner(s)/Director(s)/Senior Manager(s)/Partners and/or Principal(s).

"***Company***" refers to the incorporated organisation that this application for membership is for. If we require additional information about any holding/parent Company, we will specify this.

"***Company Officer***" is defined as including a Director, Manager or (Company) Secretary, and anyone who is to be treated as an officer of the ***Company*** for the purposes of the application.

For information on how Dental Protection uses personal data, and the rights of data subjects, please see the Privacy and Cookie Notice on our website dentalprotection.org/privacy

To be completed/authorised by Company Officer

(Please provide details of the person(s) authorised by the ***Company*** to arrange, renew or vary the membership and to discuss any relevant details with Dental Protection)

Contact details of Dental Protection practice principal director			
Title		**Dental Protection membership number**	
First name		**Address for correspondence**	
Surname			
Email address			
Daytime telephone			
Mobile (optional)			

Contact details for additional authorised person		
Title		**Address for correspondence**
First name		
Surname		
Position/job title		
Email address		
Daytime telephone		

Your Company

1. Please provide the full legal name of the entity to be indemnified, and the date it was established:
The name and number we require is that registered at Company's House. Please note that an organisation structure chart may be requested

Full legal name of *Company* to be indemnified (please also include trading name if applicable)	**Registered correspondence address**	***Company* number**	**Date of incorporation** *DD/MM/YYYY*	**Is the *Company* a subsidiary?** *Y/N* If yes – please provide the holding/parent Company name and Company number.	**Number of practices operated by the *Company***

2. Retroactive protection can be added to the Company Protection application for new members to Dental Protection. Would you like retroactive protection as part of your agreement?

☐ **Yes** ☐ **No**	If Yes please provide the date you would like the retroactive protection to start *DD/MM/YYYY*

For existing members of Dental Protection, the option to add retroactive protection was withdrawn with effect from 1 June 2024. Therefore, the start date for the Company Protection product will be the date of application.

3. Please list all locations where services are provided by practices of the *Company*, where different from the registered office, along with key areas of business:

Practice/office name	**Address**

4. Please list all Directors/ *Company Officers* at date of application:

						Has the *Company Officer* ever had:	
Name	**Start date of Directorship** *DD/MM/YYYY*	**GDC Registrant** *Y/N or N/A*	**GDC Number** *(if applicable)*	**Professional Indemnity Organisation** *eg Dental Protection or name of alternative indemnifier or insurer*	**Dental Protection Membership Number** *(if applicable)*	**any application for insurance/indemnity declined or subject to special terms or conditions or cancelled?** *Y/N* If yes please provide details in section 4a	**an adverse finding from a regulatory investigation?** *Y/N* If yes please provide details in section 4b
				Dental Protection			

If necessary please continue on page 5.

4a. Please share details of any application for insurance/indemnity that has been declined, subject to special terms or conditions or cancelled:

Insurer/Indemnifier	Date application declined or conditions added (for example at renewal or as an adjustment)	Summary of details and reason

4b. Please share information relating to any adverse finding from a regulatory investigation:

Insurer/Indemnifier	Date of adverse finding	Summary of details and reason

5. Please complete the following details.

Within the next 12 months are there any plans to increase the size of your business? *Tick Y/N and provide details if applicable*	☐ **Yes** ☐ **No**	High Level Summary

6. Are you aware of any adverse incidents, circumstances or events that may give rise to a claim against the *Company*?
Please include any that you are aware of, and/or have been reported to a previous insurer.

Insurer/Indemnifier at incident date	Date of incident	Reported to insurer/ indemnifier? *Y/N*	Summary of incident

7. Has this *Company* had previous insurance or indemnity in place for clinical negligence claims and/or vicarious liability/non-delegable duty of care claims?

☐ **Yes** ☐ **No** *If YES – please provide details of previous providers and claims history. During the process of your application, we will request a copy of your claims history obtained from your previous insurer(s). Please specify if any claims included vicarious liability or non-delegable duty of care.*

Insurer/Indemnifier (if no previous indemnity provider, please write 'none')	Date of insurance/indemnity From	 To	Summary of claim and outcome

If necessary please continue on page 5.

Your Company roles and employees

8. Do any of the dental or medical professionals who work, or have ever worked at your practice been subject to any of the following, related to their professional registration or clinical practice?

	Y/N	Number of clinicians
Open regulatory investigations		
Conditions on their professional registration		
Suspended registration		
Erasure from their professional register		
Indemnity or insurance cancelled, refused, subject to special terms, or assistance declined by any professional indemnity provider?		

9. If you have answered YES to any of the options in question 8 please provide full details including name, GDC registration number, outcome, and whether the dental professional is still working for the practice:

10. Please state all registered dental and medical professionals including any directors who are also dentists. Please also state all administrative and support roles within the company.

Company Protection is only suitable for practices/entities with a maximum of 10 dentists, 10 DCPs (with up to 2 Clinical Dental Technician) and 14 nurses.

Professional status	Maximum number of employed and self-employed working for this company at any time from the date you would like your protection to start (including any retroactive period) to present day.
Dentist	
Hygienist	
Dental Therapist	
Orthodontic Therapist	
Technician	
Dental Nurse	
Clinical Dental Technician	
Receptionist/Admin	
Practice Manager	

If necessary please continue on page 5.

IMPORTANT – Please read, confirm and date the below

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

I/we undertake to inform Dental Protection of any alterations to these facts occurring before the start of the membership and throughout any membership period.

Authorised Individual/Owner/Partner/Principal/Director:

Date — Please note this must be the current date

Print name

Position

Contact number

Email address

Additional space for answers

Please clearly indicate the question number that you are providing details for below.