

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**.
- Which employed and contracted staff are/ were indemnified by Dental Protection?

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).

"**Gross Annual Turnover**" is revenue received from providing professional services before any deductions or allowances.

"**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 or 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			

Dental Protection Limited is registered in England (No. 2374160) and is a wholly owned subsidiary of The Medical Protection Society Limited (MPS) which is registered in England (No. 00036142). Both companies use Dental Protection as a trading name and have their registered office at Level 19, The Shard, 32 London Bridge Street, London, SE1 9SG. Dental Protection Limited serves and supports the dental members of MPS with access to the full range of benefits of membership, which are all discretionary, and set out in MPS's Memorandum and Articles of Association. MPS is not an insurance company. Dental Protection® is a registered trademark of MPS.

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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 Companies 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. Would you like retroactive protection as part of this agreement?

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

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	Please confirm if any of the following are undertaken at the practice				Specialist services <i>(Please provide brief summary)</i>
		Sedation (inhalation or IV) Y/N	Implants Y/N	Non-surgical facial aesthetics Y/N		

If you have answered YES to any of the options in question 3 please confirm the types offered. All dental nurses in supporting roles should be trained in accordance with national guidance. Please advise if this is not the case:

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

Name	Start date of Directorship DD/MM/YYYY	GDC Registrant Y/N or N/A	GDC Number <i>(if applicable)</i>	Professional Indemnity Organisation <i>eg Dental Protection or name of alternative indemnifier or insurer</i>	Dental Protection Membership Number <i>(if applicable)</i>	Has the Company Officer ever had:	
						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			

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 relating to the scope and Gross Annual Turnover of the Company:

What percentage of the work of this Company is NHS vs. Private, based on Gross Annual Turnover?	Gross Annual Turnover	NHS %	Private %

Within the next 12 months are there any plans to increase the size of your business? <i>Tick Y/N and provide details if applicable</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Level Summary
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Within the next 12 months are there any plans to increase the scope/services of your business? <i>Tick Y/N and provide details if applicable</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Level Summary
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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 9 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:

Professional status	Number of self-employed FTE	Number of employed FTE	Number of Dental Protection FTE	Total self-employed Dental Protection members	Maximum number of self-employed FTE working for this Company at any time, from the date you would like you protection to start (including any retroactive period) to present day	Maximum number of self-employed Dental Protection member FTE working for this Company at any time, from the date you would like you protection to start (including any retroactive period) to present day
Dentist						
Hygienist						
Dental Therapist						
Orthodontic Therapist						
Dental Nurse						
Clinical Dental Technician						
Technicians						

11. Please state all administrative and support roles employed by the Company:

Role	Current Total FTE	Maximum FTE at any time, from the date you'd like your protection to start (including any retroactive period) to present day
Receptionist(s)		
Practice Manager(s)		
Other(s) (please specify below):		

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.