

## TDA PROFESSIONAL LIABILITY INSURANCE QUOTE REQUEST

Dentist's Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Policy Type:  Occurrence  Claims-Made Limits Desired: \_\_\_\_\_

Requested Coverage Effective Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

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### Specialty:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dental Anesthesiologist | <input type="checkbox"/> Oral & Maxillofacial Pathologist | <input type="checkbox"/> Pediatric Dentist |
| <input type="checkbox"/> Dental Public Health    | <input type="checkbox"/> Oral & Maxillofacial Radiologist | <input type="checkbox"/> Periodontist      |
| <input type="checkbox"/> Endodontist             | <input type="checkbox"/> Oral & Maxillofacial Surgeon     | <input type="checkbox"/> Prosthodontist    |
| <input type="checkbox"/> General Dentist         | <input type="checkbox"/> Orthodontist                     | <input type="checkbox"/> Oral Medicine     |
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### Procedures Performed:

- Ext of Partial Boney Impacted Third Molars  Neurotoxin(s)/Dermal Fillers  Surgical Implants
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### To determine if you are eligible for additional credit, please complete the following:

Avg Hours Worked Per Week: \_\_\_\_\_ Initial Start Date in Practice: \_\_\_\_\_

Latest Dental School End Date: \_\_\_\_\_ Residency End Date: \_\_\_\_\_

Are you now or have you ever been involved in a claim:  Yes  No

