

**PHYSICIANS REIMBURSEMENT FUND, INC.**  
**A Risk Retention Group**

**APPLICATION FOR INSURANCE — DDS & DMD**

<i>Type(s) of coverage requested:</i>	<b>Yes</b>	<b>No</b>
Part A: Patient Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Part B: Prior Acts Coverage	<input type="checkbox"/>	<input type="checkbox"/>

***Applicant Information:***

1. Name: \_\_\_\_\_  
CA Dental Lic. # \_\_\_\_\_ Expiration Date: \_\_\_\_\_
2. Type of practice or practice group:  Solo  Partnership  Corporation  Other
3. a) Name of practice or practice group: \_\_\_\_\_  
b) Name of practice manager: \_\_\_\_\_
4. Contact information:
  - a) Primary office address: \_\_\_\_\_  
\_\_\_\_\_
  - b) Primary office telephone: \_\_\_\_\_
  - c) Office facsimile number: \_\_\_\_\_
  - d) Pager number: \_\_\_\_\_
  - e) Mobile telephone: \_\_\_\_\_
  - f) E-mail address: \_\_\_\_\_
  - g) Home address: \_\_\_\_\_  
\_\_\_\_\_
  - h) Home telephone: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_
5. Dental School: \_\_\_\_\_ Date completed: \_\_\_\_\_
6. Internship: \_\_\_\_\_ Date completed: \_\_\_\_\_
7. Residency: \_\_\_\_\_ Date completed: \_\_\_\_\_
8. Specialty Society Memberships: \_\_\_\_\_  
\_\_\_\_\_
9. Hospital Staff Affiliations: \_\_\_\_\_  
\_\_\_\_\_
10. Teaching Appointments: \_\_\_\_\_
11. Do you intend to practice more than 3 hours per week at any office or clinic (practice location) other than the primary office identified above?

Yes  No

If “Yes,” please provide the following information for each additional practice location:

- a) Office address: \_\_\_\_\_  
\_\_\_\_\_
- b) Office telephone: \_\_\_\_\_
- c) Office facsimile number: \_\_\_\_\_
12. Have you ever received any claim, demand for compensation, notice of intent to sue, summons or demand for arbitration arising from professional services rendered?

Yes  No

If “Yes,” please provide the following information for each such claim:

- a) Date of Incident: \_\_\_\_\_
- b) Nature of Claim: \_\_\_\_\_
- c) Date Resolved: \_\_\_\_\_

d) Nature of Resolution (including amount of any settlement or judgment or award):

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Use a separate page if necessary.

13. Names and dates of coverage of any previous or existing professional liability insurers. (An authorization to obtain your liability history from such insurers is attached.)

Name of Insurer

Dates of Coverage

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14. Has your professional liability coverage ever been cancelled or not renewed?

Yes                       No

If “Yes,” please provide the name of the insurer and the reasons given (if any) for the cancellation or non-renewal:

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15. Identify any special procedures you perform or participate in which could be regarded as innovative, experimental or for which long-term follow-up has not been established:

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16. Has your license to practice your profession in any jurisdiction or your Drug Enforcement Agency or other controlled substances authorization ever been limited, suspended, revoked, denied or subjected to probationary conditions, or have proceedings toward any of those ends been instituted?

Yes                       No

17. Have you ever voluntarily relinquished any medical staff membership, clinical privileges, professional license(s) or narcotics registration under threat of disciplinary action?

Yes  No

18. Have you ever been denied membership on any hospital medical staff, or advancement in medical staff status, or has such a denial been recommended by a standing medical staff committee or governing board?

Yes  No

19. Has your medical staff membership or medical staff status or your clinical privilege(s) at any hospital ever been limited, suspended, revoked, not renewed or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a standing medical staff committee or governing board?

Yes  No

20. Has your request for any specific clinical privileges ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a standing medical staff committee or governing board?

Yes  No

21. Do you have any mental or physical health problems that may affect your ability to practice or the quality of your practice?

Yes  No

22. Have you ever been denied certification, or has your eligibility status changed with respect to certification, by a specialty board?

Yes  No

23. Has any investigation, review or audit by a provider organization (IPA, MSO or HMO) or other credentialing agency ever resulted in penalties, restrictions, or modification of your privileges or provider status?

Yes  No

24. Have you ever been convicted of a felony or have any felony charges been filed against you?

Yes                       No

***If the answer to any of questions 16 through 24 is “Yes,” or if you wish to provide any other pertinent information, please include full details on a separate page.***

*I certify that the information contained in this application is complete and correct to the best of my knowledge, and I understand that PRF-RRG will be relying upon this information in reaching its decision whether to extend insurance coverage to me.*

Name: \_\_\_\_\_  
(Please print)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTICE:**  
This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

**AUTHORIZATION FOR THE RELEASE OF INSURANCE INFORMATION**

The undersigned hereby authorizes and requests the release by each and any of his/her former or present professional liability insurance providers of any and all information, whether confidential or otherwise, requested by the Physicians Reimbursement Fund, Inc., A Risk Retention Group or its representatives.

For purposes of the above, a copy of this authorization shall be sufficient accompanying any request for information. This Authorization shall be effective for six months from the date executed.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_  
(Please print)

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

Physicians Reimbursement Fund, Inc.,  
A Risk Retention Group  
711 Van Ness Avenue, Suite 430  
San Francisco, CA 94102  
Attention: June Riley

Re: Sphargis Inc. Share Purchase

Dear Ms. Riley:

The undersigned applicant for insurance hereby applies for one share of Class A stock in Sphargis Inc., a California corporation, having a par value and a purchase price of \$1.00 (one dollar). I acknowledge that my rights and obligations with respect to this stock are as described in the Articles of Incorporation as amended and in the Bylaws of Sphargis Inc., copies of which are available upon my request. I also acknowledge that I must continue to hold this share so long as I am an insured of the Physicians Reimbursement Fund, Inc., A Risk Retention Group, (PRF) and that the share is subject to repurchase at its original price in the event I cease to be an insured.

Yours truly,

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

Please return the completed application (including attachments) together with the following:

- A copy of Applicant's most current curriculum vitae
- A check for \$200 made out to the PRF (non-refundable application fee)
- A check for \$1 made out to Sphargis, Inc. for required share purchase

**Physicians Reimbursement Fund Inc., A Risk Retention Group**

711 Van Ness Avenue, Suite 430  
San Francisco, CA 94102

415/921-0498 (Telephone)

415/921-7862 (Facsimile)

NOTICE: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.