challenge

Dental Practitioner Application Form

IMPORTANT INFORMATION – PLEASE READ

This Application Form, which is designed for dentists on the Irish Dental Council's register, must be signed by the Applicant.

It is the duty of the Applicant to disclose all material facts. For the purpose of this Application Form, a material fact shall be deemed to be one that would be likely to influence the judgement of a prudent insurer in fixing the premium or determining whether to underwrite the risk.

Each section of this Application Form must be completed in full. Incomplete or unsigned forms will not be accepted.

Should there be insufficient room on any part of the Application Form to record all necessary details, please use the space provided in Section 5 with reference to the appropriate question.

Failure to disclose full and accurate details may entitle Insurers to void your contract of insurance and will mean that you are not entitled to any benefits of, nor make any claims against, your policy.

It is the responsibility of the Applicant to notify any future change of address or any changes in their professional circumstances.

Once completed, please sign and date the Declaration in Section 6 and return it to:

Challenge Insurance Brokers Limited
Challenge House, 11 Burnell Square,
Mayne River Way, Malahide Road, D17 VY04.

Email: insurance@challenge.ie
Tel: +353 1 8395942

Limits of Indemnity

Any One Claim	Annual Aggregate
€1,000,000	€2,000,000

Policy Excess

The excess on this policy is NIL each and every claim

Should you have any questions, please contact Challenge Insurance Brokers Limited on +353 1 8395942.

THE SIGNING OF THIS APPLICATION FORM DOES NOT BIND THE APPLICANT, OR INSURERS, TO COMPLETE A CONTRACT OF INSURANCE.

Section 1 – Personal Details

Title

Forename

Surname

Date of Birth 1 1 2017

Residential Address (for all correspondence)

Email Address

Contact No.

Mobile No.

Practice Website

IDC Registration No.

IDC Registration Type

Practice Address

Section 2 – Practice Profile

1. In relation to your private practice only, please confirm:

   a. You are a General Dental Practitioner Only meaning you do not perform Orthodontic work, Implant Work, Sinus Lifts, Periodontology (except non-surgical work), bone grafting etc. or Botox and fillers. Yes ☐ No ☐

   b. If you perform any of the folllowing noted work can you confirm the % spilt of work between your General Dentistry Work & other specialities

General Dentistry	%
Implants	%
Orthodontics	%
Periodontics	%
Bone Grafts	%
Sinus Lifts	%
Botox/Fillers	%
Other	%

   c. Please list procedures you perform that are not listed above

2. In your private practice do you perform maxillofacial surgery other than routine oral (dento-alveolar) surgery? Yes ☐ No ☐

3. Do you plan to cease **all** practice in the next 5 years? Yes ☐ No ☐

4. Please state the approximate percentage split between each of the following categories.

   a) Private Practice % (incl Medical Card Scheme Income) % b) Public Practice % (directly for HSE) %

5. Do you perform work outside the Republic of Ireland? Yes ☐ No ☐
   (If "Yes", where? Please use additional space provided in Section 5)

Section 3 – Professional History

1. What year did you begin private practice? 2030

2. Please provide details of current insurance, if applicable.

Indemnity/Insurance Provider	Year First Joined	Renewal / Expiry Date	Subscription in Current Year
	2023	1 2023	€

3. Has your indemnity been continuous since qualification? Yes ☐ No ☐
   If "No", please provide details in Section 5)

4. Has any application for this type of insurance cover or membership of any defence body ever been declined, cancelled or required special terms? Yes ☐ No ☐
   (If "Yes", please provide details in Section 5)

5. Have any claims for compensation been made against you for incidents or circumstances arising from public or private practice during the last 10 years? Yes ☐ No ☐
   (If "Yes", please provide a print out of all cases from your current and previous indemnifier(s) or insurer(s))

6. Are you aware of any circumstances, from your public or private practice, which may give rise to a claim against you? Yes ☐ No ☐
   (If "Yes", please provide the relevant date with brief details using additional space in Section 5)

7. Have all of the circumstances listed above been notified to your current indemnity provider or insurer? Yes ☐ No ☐

8. Have you ever been convicted of any criminal offence (other than minor driving offences), and/or subject to professional disciplinary proceedings by your Employer and/or IDC Fitness to Practice procedures? Yes ☐ No ☐
   (If "Yes", please provide brief details in Section 5)

Section 4 – Financial Information

1. What is your gross annual income from your private practice, excluding both dento-legal and HSE/CIS indemnified work?

   a) for the past accounting year? € b) estimated for the full current accounting year? €

2. What is your gross annual income from dento-legal work only in your private practice?

   a) for the past accounting year? € b) estimated for the full current accounting year? €

3. Do you provide your services or bill your patients via a Limited Company, or a similar joint venture?
   (If "Yes", please complete 4. a), b), c) and d).)

   a) If applicable, please provide the company name and number. Company Name Number

   b) Is the company set up solely for fiscal reasons? Yes No

   c) Are you the only registered medical practitioner working for the Company? Yes No

   d) Does the Company or you employ medically qualified and/or auxiliary staff? Yes No

   e) If applicable, do you require cover for any of the staff declared above? Yes No

Section 5 – Additional Information

Section 6 – Declaration and Disclosure

I declare and warrant that, after enquiry, all statements and declarations contained in the completed Application Form, together with any and all other information, statements and declarations made to Insurers, or their representatives, by or on behalf of the Insured, whether written or oral, are true and that no information whatsoever has been withheld which might increase the risk to Insurers or influence the acceptance of this Application Form. Should the above statements and declarations alter in any way, I will advise Challenge as soon as practicable. I understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of this Application Form may result in the refusal to provide indemnity or voiding the policy in every respect. I hereby accept that this Declaration shall be the basis of the contract between both parties if entered into. By signing this document, I authorise Challenge to release information to necessary third parties and give permission for Challenge to use my email address, as provided in Section 1, to send their quotations or correspondence.

Customer Signature Print Name

Date 1 1 2023