



## **Professional Information**

7. Colorado Dental License # \_\_\_\_\_ DEA# \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_

8. Have you ever been licensed in another state? List all

License # \_\_\_\_\_ Current? Yes No

9. Dental School Attended \_\_\_\_\_

10. Month/Year of Graduation \_\_\_\_/\_\_\_\_

11. If you are a Foreign Dental School Graduate, are you certified by the Educational Council for Dental School Graduates: Yes No If yes, year of certification \_\_\_\_\_

12. Have you completed a residency? Please list \_\_\_\_\_ Date Completed \_\_\_\_/\_\_\_\_

13. Please list any other Professional Licenses:

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14. In consideration of the issuance of this coverage, the applicant agrees to become a member of the Colorado Dental Association and maintain membership. \_\_\_\_\_(initials)

What professional organizations are you a member of? ADA CDA (required)

Other: \_\_\_\_\_

## **About Your Practice:**

Employee Dentist Individual Partnership Professional Corporation Contract Dentist

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

Additional Locations: \_\_\_\_\_

Name of Partners or Members of Corporation/Employer \_\_\_\_\_

Are other dentists employed or contract providers employed by you? Yes No Number Employed \_\_\_\_

Are they Trust Dentists? Yes No

## License and Claims History

15. Do you have hospital privileges?      Yes                      No

*Please provide details:* \_\_\_\_\_

List Dental Assistants: \_\_\_\_\_

16. Has any dental school or governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, voluntarily surrendered, denial or other sanctions?      Yes                      No

*If yes, provide a copy of the board transcript or other documentation, including resolution.*

17. Have you ever been denied a dental license or been denied certification by a specialty board?

Yes                      No

*If yes, provide details:* \_\_\_\_\_

18. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency including Peer Review?      Yes      No

*If yes, provide a copy of the board transcript or other documentation, including resolution.*

19. Have you been convicted of any criminal charges?      Yes                      No

*Please provide details:* \_\_\_\_\_

20. Have you ever been or are you currently being treated for:

Alcohol abuse                      Yes                      No

Drug Addiction                      Yes                      No

Mental Illness                      Yes                      No

Physical Disablement                      Yes                      No

*If yes, provide a letter from treating physician with complete details.*

21. Has any claim or suit for alleged malpractice ever been brought against you?      Yes                      No

*If yes, please provide details and copies of settlement.*

22. Are you currently aware of any situation that could lead to a malpractice suit against you?    Yes    No

If yes, provide details: \_\_\_\_\_

23. Retroactive Coverage.

Carrier and dates covered: \_\_\_\_\_

Retroactive Coverage Desired: *Be exact by day* \_\_\_\_\_ to \_\_\_\_\_

## **Procedures Performed**

24. Indicate which of the following areas you plan to practice:

Examination, diagnosis, treatment planning	Preventive Dentistry
Implantology    Surgical    Restorative	Prosthodontics, Fixed
Pediatric Dentistry	Prosthodontics, Removable
Operative Dentistry	Oral Surgery
Orthodontics	Cosmetic Dentistry
Endodontics	TMJ/TMD
Periodontics	Hospital Dentistry
Neurotoxins and Dermal Fillers	Deep Sedation

25. Indicate the following dental techniques or procedures you perform, or someone under your direct supervision/direction will perform:

Sleep Apnea Therapy	Physical Therapy
Lasers – used in dental treatment	Molar Endodontics
Extraction of Impacted Teeth	
Implant Dentistry (If yes, provide copies of training and certificates)	
Surgical Placement (please complete Implant Application)	
Restorative	
Sedation (If yes, provide the required State documentation and complete Anesthesia/Sedation Application)	
General Anesthesia	Nitrous Oxide/Oxygen Inhalation
Moderate Sedation	Oral Premedication for anxiety & apprehension
Minimal Sedation	

Who administers the anesthesia?

You

Another Dentist or MD Anesthesiologist or CRNA

Comprehensive Radiographic Survey (FMX)? Yes No

How frequently? \_\_\_\_\_

CT Imaging

Is the equipment used on patients other than your own? Yes No

Are the results read by a radiologist? Yes No

Cosmetic Dentistry/Rehabilitation/TMJ/TMD (If yes, please copies of any training)

Botox/Dermal procedures (If yes, provide copies of training and certification and complete Application)

26. Do you obtain a dental/medical history for all patients? Yes No

27. Do you personally review it? Yes No

Is that history updated? Yes No

How frequently? \_\_\_\_\_

28. Do you complete patient charts? Yes No

Immediately after treatment End of each day End of each week

29. Do you have written informed consent documents in your office? Yes ~~Yes~~ No  
If yes, list for what procedures: \_\_\_\_\_

30. Do you record a comprehensive/detailed treatment plan in the patient's chart? ~~Yes~~ ~~Yes~~ No

Do you have a patient consultation of your treatment plan that is approved and signed by the patient? Yes No

31. Do you have established emergency procedures, personnel trained in BLS and equipment for patient emergencies such as cardiac arrest, etc? Yes No

Please provide details: \_\_\_\_\_

CPR Certification Date \_\_\_\_\_

AED

Emergency Kit

## SUPPLEMENTAL REPORT FORM

As indicated in Questions 16, 21, 22 of the Professional Liability Coverage Application, the following information is required. Complete a separate form for each incident/claim or suit regardless of the disposition of the complaint, claim or incident.

(make copies of this form if you need to report multiple incidents/claims or complaints)

1. Name, age and sex of patient: \_\_\_\_\_

2. Date of first examination: \_\_\_\_\_

3. Dental condition and diagnosis at first examination: \_\_\_\_\_

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4. Dates of treatment and nature of treatment: \_\_\_\_\_

5. Date of incident/claim, and allegations made \_\_\_\_\_

6. Disposition of the incident/claim and amount of judgement or settlement \_\_\_\_\_

7. What insurance company, if any, was involved: \_\_\_\_\_

8. Subsequent condition/health of the patient: \_\_\_\_\_

9. Name of other doctors, if any, involved in the incident/claim or suit: \_\_\_\_\_

10. To whom may we refer for further information about the claim/suit: \_\_\_\_\_

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Dated



## **BUSINESS ASSOCIATE AGREEMENT**

### *Board of Directors*

Neil D. Schoemaker, DDS  
*President*  
*Northeastern Colorado*

J. Gregory Mann, DDS  
*Vice President*  
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*Larimer County*

Richard A. Hurd, DDS  
*Western Colorado*

Kami Marr, DDS  
*Weld County*

Sarah Parsons, DDS  
*Metropolitan Denver*

Brian Todd Pickle, DDS, MS  
*Colorado Springs*

Ben Ricketts, DDS, MSD  
*Metropolitan Denver*

R.J. Schultz, DDS  
*South East*

Michael Varley, DDS  
*Ex officio member*  
*Colorado Dental Association*

Lonnie R. Johnson, DDS, PhD  
*Ex officio member*  
*University of Colorado*  
*School of Dental Medicine*

Lindsay Compton, DDS  
*New Dentist Committee Member*

Greg Hill, J.D.  
*Ex officio member*  
*Colorado Dental Association*  
*Executive Director*

Administered by  
*Berkley Risk*  
email  
*denver@berkleyrisk.com*  
Internet  
*http://www.tdplt.com*  
*Metro Denver*  
*(303) 357-2600*  
*Toll Free*

This **BUSINESS ASSOCIATE AGREEMENT** (“Agreement”) is entered into effective as of September 23, 2013 or any date thereafter under which “Protected Health Information” is involved (the “Effective Date”) by and between \_\_\_\_\_

the Participant’s dental practice, collectively referred to herein as “**Participant**”, and the **Dentists Professional Liability Trust of Colorado** acting through its governing Board (“**Trust**”) and its Program Administrator, **Berkley Risk Administrators Company, LLC** (“**BRS**”). The Trust and BRS shall be referred to herein as “Business Associate” and all entities shall collectively be referred to as the “Parties.”

### **RECITALS:**

**WHEREAS**, Participant is a “health care provider” and is or may become a “covered entity” as those terms are used and defined in the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), and its implementing regulations;

**WHEREAS**, Business Associate performs or may perform services for or on behalf of Participant (the “Services”) pursuant to the Coverage Agreement and the related Trust Agreement (the “Underlying Agreements”), which Services involve or may involve the access, use and/or disclosure of Protected Health Information (as defined below); and

**WHEREAS**, the Parties desire to enter into this Agreement in order to comply with the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), the HIPAA amendments issued pursuant to the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, and the implementing regulations.

**NOW THEREFORE**, in consideration of the obligations set forth herein and other good and valuable consideration the Parties agree as follows:

**1. Definitions.** Capitalized terms not otherwise defined in this Agreement shall have the same meaning as those terms in the HIPAA Privacy, Security, Enforcement & Breach Notification Final Omnibus Rules as they exist or as they may be amended from time to time (the “HIPAA Rules”).

(a) “Breach” shall have the meaning set forth in 45 CFR § 164.402 (including all of its subsections).

(b) “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 C.F.R. § 164.501.

(c) “Electronic Protected Health Information” or “EPHI” shall have the same meaning as the term “electronic protected health information” in 45 CFR § 160.103, limited to information that Business Associate creates, accesses, receives or maintains for or on behalf of Participant.

## **BUSINESS ASSOCIATE AGREEMENT**

(d) “Protected Health Information” or “PHI” shall have the meaning set forth in in 45 CFR § 160.103, limited to information that Business Associate creates, accesses, receives or maintains for or on behalf of Participant. PHI includes EPHI.

(e) “Privacy Rule” means the Standards for Privacy of Individually Identifiable Health Information, codified at 45 CFR parts 160 and 164, Subparts A, D and E, as currently in effect.

(f) “Security Rule” means the Standards for Security for the Protection of Electronic Protected Health Information, codified at 45 CFR parts 160 and 164, Subparts A and C, as currently in effect.

(g) “Unsecured Protected Health Information” shall have the same meaning as the term “unsecured protected health information” in 45 CFR § 164.402, limited to such information accessed, created, received or maintained by Business Associate.

### **2. Scope of Use and Disclosure of PHI.**

(a) Business Associate Status. Business Associate acknowledges that it is or may become the Participant’s “Business Associate” as defined by HIPAA or the HIPAA Rules. Business Associate agrees to comply with HIPAA, HITECH and the HIPAA Rules as they directly apply to business associates.

(b) Performance of Service. Business Associate shall not access, use or further disclose PHI, other than as permitted or required by this Agreement, to perform the Services pursuant to the Underlying Agreements or as required by law. Business Associate shall not access, use or disclose PHI in any manner that would violate HIPAA or the HIPAA Rules if such access, use or disclosure was done by Participant.

(c) Permitted Uses and Disclosures. Business Associate is authorized and entitled to use the PHI for the necessary and proper management and administration of the Trust and the Coverage Agreement including, expressly, but not necessarily limited to:

1. Any and all risk management functions;
2. The defense of, handling of, and any other activities related to, any incident or claim submitted by any patient or patient representative against the Participant for which the Coverage Agreement provides or may provide coverage to the Participant in any judicial or administrative proceeding initiated against the Participant;
3. The handling of responses to administration of or other activities related to any dental incident or other incident or wrongful act alleged against the Participant and which is covered and as provided for by the Coverage Agreement;
4. Cooperation with the Trust and any and all of the Trust's representatives and subcontractors, including defense counsel and expert witnesses, related to the defense or settlement of any notice of a claim or dental incident or wrongful act;
5. The enforcement of any right of contribution of the Trust against any other person or entity who may be liable to the Participant or the Trust because of any



## **BUSINESS ASSOCIATE AGREEMENT**

damages to which the Coverage Agreement applies;

6. Assistance in securing and giving evidence and obtaining of witnesses in defense of any proceeding against the Participant;
7. The investigation, settlement or defense of any claim; or
8. The assistance and cooperation with the Trust in the event any need exists in the judgment of the Trust to assist in or investigate any regulatory proceedings including, but not limited to, any such proceedings brought by the Colorado Board of Dental Examiners

Business Associate may also use any such PHI related to the functions and activities set out in the prior paragraphs in association with information they have and in their capacities as a Business Associate and/or as a subcontractor with or to defense counsel, coverage counsel, or expert witnesses as required by the circumstances or such activities as set forth in the prior paragraphs.

All of the foregoing are subject to the express conditions and terms of the Trust Agreement and the Coverage Agreement and any applicable endorsements.

(d) Minimum Necessary. Business Associate shall not access, use or disclose more than the minimum necessary PHI to perform or fulfill the intended permissible purpose, in accordance with this Agreement.

(e) Privacy Rule. To the extent Business Associate carries out one or more of the Participant's obligations under the HIPAA Privacy Rule, Business Associate shall comply with the requirements of HIPAA that apply to the Participant in the performance of such obligation(s).

(f) Security Rule and Safeguards. Business Associate shall use safeguards that are appropriate and sufficient to prevent access, use or disclosure of PHI other than as permitted or required by this Agreement. Business Associate shall comply with the Security Rule with respect to EPHI, including implementing Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of EPHI.

(g) Notification. Without unreasonable delay, and in no event in less than ten (10) days from discovery of a Breach, Business Associate shall notify the Participant, in writing, of any use or disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware. Without unreasonable delay, Business Associate shall report to Participant in writing of any Security Incident of which it becomes aware in accordance with the Security Rule and Business Associate's obligations under the same. Upon Participant's or the Participant's request, Business Associate shall provide a report of any and all impermissible uses, disclosures and/or Security Incidents.

(h) Subcontractors. Business Associate shall ensure that any and all subcontractors that create, receive, maintain or transmit PHI on behalf of Business Associate agree, in writing, to the same restrictions and conditions that apply to Business Associate. Each subcontract agreement must include, without limitation, the provisions of this Agreement. Business Associate shall make such agreements with its subcontractors available to the

## **BUSINESS ASSOCIATE AGREEMENT**

Participant upon request.

(i) Audit. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of the Participant available to the Secretary of Health and Human Services and/or the Participant, upon request, for purposes of determining and facilitating Participant's compliance with HIPAA.

(j) Patient Rights.

1. Patient Right to Review. It is understood that the PHI and EPHI is expected to be exempt from access or accounting to the patient under the HIPAA Rules, §§ 164.524 and 164.528 of 45 C.F.R. In the event that any such PHI or EPHI records are not exempt, Business Associate shall make PHI or EPHI maintained in a Designated Record Set available to Participant in accordance with §164.524 of the Privacy Rule.

2. Patient Right to Amend. Business Associate shall make PHI available for amendment and incorporate any amendments to PHI maintained in a Designated Record Set at the direction of Participant and in accordance with §164.526 of the Privacy Rule. Participant shall be involved in any decision of Business Associate to amend the PHI of an Individual.

3. Patient Right to Request Accounting. Business Associate shall document and make available to Participant information relating to such Individual as is necessary for Participant to respond to a request for an accounting of disclosures in accordance with §164.528 of the Privacy Rule.

A. Business Associate agrees to implement an appropriate record-keeping process to ensure compliance with the requirements of this Section.

B. Business Associate, if the access or accounting is not exempt under the HIPAA Rules, agrees to provide PHI it maintains electronically in a Designated Record Set in an electronic form at the request of Participant and, when applicable, the Dental Practice or an Individual.

4. Notice to Participant. Business Associate shall notify the Participant immediately in writing upon receiving a request from an Individual to review copy or amend his or her medical record information or to receive an accounting of disclosures. Business Associate shall also provide Participant with a prompt written report of the details of its handling of such requests.

(k) Breach. Business Associate shall notify Participant of breaches of Unsecured PHI in accordance with the requirements of 45 CFR § 164.410 and in no event later than ten (10) days following discovery of any Breach. Such notification shall include, to the extent possible, the identification of each Individual whose PHI has been or is reasonably believed to have been accessed, acquired, used or disclosed during the Breach, along with any other information that Participant will be required to include in its notification to an affected Individual, the media and/or the Secretary, as applicable, including, without limitation, a description of the Breach, the date of the Breach and its discovery, the types of Unsecured Protected Health Information involved and a description of Business Associate's investigation, mitigation and prevention efforts.

(l) Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by

## **BUSINESS ASSOCIATE AGREEMENT**

Business Associate or a subcontractor or agent of Business Associate in violation of the requirements of this Agreement, the Privacy Rule, the Security Rule or other applicable federal or state law.

### **3. Participant Obligations.**

(a) Notice of Privacy Practices. Participant shall notify Business Associate of limitation(s) in its notice of privacy practices to the extent such limitation affects Business Associate's permitted uses or disclosures under this Agreement.

(b) Individual Authorization. Participant shall notify Business Associate of changes in, or revocation of, authorization by an Individual to use or disclose PHI, to the extent such changes affect Business Associate's permitted uses or disclosures under this Agreement.

(c) Restrictions. Participant shall notify Business Associate of restriction(s) in the use or disclosure of PHI that Participant has agreed to, to the extent such restriction affects Business Associate's permitted uses or disclosures under this Agreement.

### **4. Term and Termination.**

(a) Term. The Term of this Agreement shall become effective as of the Effective Date, and remain in effect until all PHI or EPHI is returned or destroyed in accordance with this Section.

(b) Termination for Cause. Participant may terminate this Agreement immediately if Participant, in its sole discretion, determines that Business Associate has violated a material term of this Agreement. Participant, at its option and within its sole discretion, may (1) permit Business Associate take steps to cure the breach; and (2) in the event Participant determines such cure is sufficient, elect to keep this Agreement in force.

(c) Obligations of Business Associate upon Termination. Upon termination of this Agreement for any reason, Business Associate shall promptly return to Participant or destroy all PHI received from Participant, or created or received by Business Associate on behalf of Participant, that Business Associate still maintains in any form. Business Associate shall retain no copies of the PHI in any form. Upon request by Participant, Business Associate shall promptly supply a certification executed by an authorized representative of the Business Associate confirming that Business Associate has returned or destroyed all PHI and all copies thereof.

(d) Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

### **5. Miscellaneous Provisions.**

(a) Notices. Any notice required or permitted under this Agreement will be given in writing and will be sent via email or facsimile with hard copy to follow via Certified Mail, Return Receipt Requested:

To Participant at:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BUSINESS ASSOCIATE AGREEMENT**

To Business Associate at:

Dentists Professional Liability Trust of Colorado  
c/o Berkley Risk Administrators Company, LLC.  
Attn: Dr. Randy Kluender  
7807 East Peakview Avenue, Suite 350  
Centennial, CO 80111

(b) Waiver. No delay or omission by any party to exercise any right or remedy under this Agreement will be construed to be either acquiescence or the waiver of the ability to exercise any right or remedy in the future. Failure of a party to insist upon strict adherence to any term

or condition of this Agreement shall not be considered a waiver by that party of its right thereafter to insist upon strict adherence to that, or any other, term or condition of this Agreement. No waiver of any breach of any provision of this Agreement shall constitute a waiver of any prior, concurrent or subsequent breach of the same or any other provisions hereof, and no waiver shall be effective unless made in writing and signed by an authorized representative of the waiving party.

(c) Severability. All provisions of this Agreement are separate and divisible, and if any part or parts of this Agreement are held to be unenforceable, the remainder of this Agreement will continue in full force and effect.

(d) Amendments. The Parties shall confer and may amend this Agreement from time to time by mutual written agreement as may be necessary in order to keep this Agreement consistent with any changes made to the HIPAA or HITECH laws or HIPAA Rules. Participant may terminate this Agreement if the Parties are unable to agree to such changes by the compliance date for such new or revised HIPAA or HITECH laws or HIPAA Rules.

(e) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with HIPAA and HITECH and the HIPAA Rules.

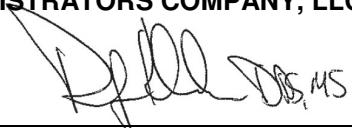
(f) Independent contractor. The Parties acknowledge and agree that Business Associate is an independent contractor. Nothing in this agreement shall be construed to create any partnership, joint venture, agency, or employment relationship of any kind between the Parties. Notwithstanding the foregoing, to the extent that Business Associate is ever determined for any purpose to be an agent of the Participant (under the Federal common law of agency or otherwise), Business Associate shall be acting outside of the scope of agency if Business Associate fails to notify the Participant immediately if Business Associate violates or breaches any provision of this Agreement or violates the HIPAA Rules.

(g) Integration. In the event the Business Associate and Participant were parties to a prior Business Associate Agreement, such prior Agreement is superseded and replaced by this Agreement.

**IN WITNESS WHEREOF**, the Parties have executed this Business Associate Agreement as of the Effective Date.

**DENTISTS PROFESSIONAL LIABILITY TRUST OF  
COLORADO AND BERKLEY RISK  
ADMINISTRATORS COMPANY, LLC**

By: **X** \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

By:  \_\_\_\_\_  
Name: Randy L. Kluender, DDS, MS  
Title: Executive Director

## PARTICIPATION AGREEMENT

for

### DENTISTS PROFESSIONAL LIABILITY TRUST OF COLORADO

THIS AGREEMENT, is entered by the undersigned "Participant" and The Dentists Professional Liability Benefit Plan, Inc., a Colorado corporation ("Trustee") as Trustee of The Dentists Professional Liability Trust dba Dentists Professional Liability Trust of Colorado ("Trust").

WHEREAS, the Participant, upon acceptance as a Participant in the Trust, is thereby entitled to purchase a professional liability policy upon such conditions as shall be determined from time to time by the Trustee.

NOW, THEREFORE, for and in consideration of the mutual promises herein contained, it is agreed as follows:

1. Participant acknowledges that he has received a copy of the Trust Agreement for Dentists Professional Liability Trust of Colorado (the "Trust Agreement") as revised (effective 4/13/99) and has reviewed its contents, including the provisions relating to termination of Participation. The Participant agrees to comply with all terms and conditions of the Trust Agreement, including any modifications thereof or supplements thereto, and any coverage agreement between the Trust and Participant, as well as any rules, regulations, eligibility requirements, and policies adopted by the Trustee from time to time; the provisions of all the foregoing, as amended from time to time are incorporated herein by this reference.

2. The Trustee agrees to provide Participant with professional liability coverage in such amounts and upon such conditions as Trustees shall prescribe from time to time, which coverage will be evidenced by a Coverage Agreement (Policy).

3. The Participant acknowledges that participation in the Trust and any professional liability coverage provided by the Trust are subject to termination as provided in the Trust Agreement, this Participation Agreement, or any professional liability Coverage Agreement provided by the Trustee.

4. Participant acknowledges that the purpose of participation in the Trust is to permit the Participant to purchase professional liability coverage, upon such terms and conditions as the Trustee shall establish. The Trust contributions paid by Participants for each policy year are intended to pay the cost of such professional liability coverage as may be issued by the Trust and to generate such reserves as the Trustee shall determine are advisable from time to time.

5. Participant agrees to pay all premiums when due for policies issued to him in accordance with rate schedules prepared by the Trustee from time to time.

6. Participant agrees to release to the Trustee all past and current information pertaining to underwriting, and claims by Participant's prior professional liability insurers, or their agents.

7. Participant agrees that termination or non-renewal of his participation in the Trust shall automatically terminate any coverage provided by the Trust to Participant; and that termination or non-renewal of any coverage provided by the Trust to Participant shall automatically terminate Participant's participation in the Trust. Upon termination or non-renewal of Participation in the Trust, any interest in the Trust assets to which Participant would otherwise be entitled will be forfeited; and the payment of such claims and other benefits as are provided in the Coverage Agreement or other agreement issued by the Trustee to Participant shall be the only continuing benefit to which Participant shall be entitled, the payment thereof to be subject to the provisions of such Coverage Agreement or other agreement.

PARTICIPATION AGREEMENT

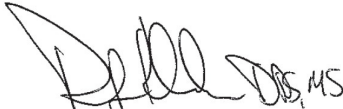
8. In the event of the termination, merger or consolidation of the Trust, the Trust Assets may be transferred or disposed of in such manner as shall be determined by the Trustee in accordance with the Trust Agreement, as amended from time to time, and in accordance with the provisions hereof; provided, however, that only those persons who, at the time of such termination, merger or consolidation, are Participants of the Trust shall be deemed to have any interest in the Trust Assets. Participant understands and agrees that his interest in the Trust Assets shall be contingent in nature, and shall be subject to forfeiture as provided in paragraph 7 above.

9. Participant recognizes that the Trust Agreement grants broad authority to the Trustee in operation and management of the Trust; and specifically grants broad authority for election and removal of the Trustee, and for reorganization or termination of the Trust to a voting majority of Participants. Participant agrees that in the event of any such merger, consolidation or reorganization of the Trust resulting in the creation of any successor entity, such a merger, consolidation, or reorganization shall not constitute a termination or any other event or change of circumstances which would require any distribution of assets of the Trust to Participants.

10. In the event of any conflict or inconsistency between the provisions of this Participation Agreement and those of the Trust Agreement, as amended from time to time, the provisions of the Trust Agreement, as amended, shall govern and control the rights and obligations of the parties hereunder.

IN WITNESS WHEREOF, the parties have affixed their signatures:

THE DENTISTS PROFESSIONAL  
LIABILITY BENEFIT PLAN, INC.  
Trustee:



By : Randy L. Kluender, DDS, MS  
Executive Director  
Berkley Risk Administrators Company, LLC

PARTICIPANT:

X \_\_\_\_\_

\_\_\_\_\_  
Date