**ENTITY COVER APPLICATION FORM**

**Your name:**

**GDC Number** **or Indemnity policy number:**

**Name of the entity to be added to the policy:**

**Main practice address:**

**Practice website address:** http://

**How many practice locations does the entity operate from?**

**Business description:** Dental Practice

1. **Do you require cover for your Limited Company?**

Yes/No *delete as applicable*

1. **Do you currently have an entity policy in place?**

Yes/No *delete as applicable*

Please note the renewal date of that policy: dd/mm/yyyy

1. **You confirm that as a BDA Indemnity policyholder(s), you have equal to or more than 50% of shares in the Limited Company to be covered:**

Yes/No *delete as applicable*

1. **You confirm the Limited Company checks and holds details of Professional Indemnity cover for all dentists in the entity:**

Yes/No *delete as applicable*

1. **You confirm the Professional Indemnity details of all dentists are checked annually and include information relating to the insurer/defence organisation including a retroactive date if applicable:**

Yes/No *delete as applicable*

1. **Have you had any complaints against the Limited Company in the last 5 years?**

Yes/No *delete as applicable*

If yes, please provide details

1. **Have you had any claims against the Limited Company in the last 5 years?**

Yes/No *delete as applicable*

If yes, please provide details

1. **Has there been any regulatory action against the Limited Company in the last 5 years?**

**(e.g., Care Quality Commission, Prudential Regulatory Authority, NHS Commissioning body Financial Conduct Authority, Advertising Standards Authority)**

Yes/No *delete as applicable*

*If yes, please provide details here:*

1. **Please confirm the most recent annual gr turnover for the Limited Company:**

£

1. **Are any of the dentists working for the entity BDA Indemnity policyholders**

Yes/No *delete as applicable*

*If yes, please provide their names, GDC number and the percentage shareholding where applicable.*

|  |  |  |
| --- | --- | --- |
| Name | GDC number | If this person has a share in the Limited Company, please indicate the percentage |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Are there any dentists working in the practice on a GDC Specialist register?**

Yes/No *delete as applicable*

If yes, please confirm which register and how many

|  |  |
| --- | --- |
| Specialist Register | Number of dentists engaged by the entity on that list |
|  |  |
|  |  |
|  |  |
|  |  |

1. **How many dentists work in the practice(s)/entity excluding those listed above in Q10 above?**
2. **On which date would you wish this entity cover to start?**
3. **Do you want to start this cover from when your BDA Indemnity policy started (retroactive cover)?**

Yes/No *delete as applicable*

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