PSIC | RPG Association

# Dental Professional Liability Application

**Please remember to attach a copy of the following with the application:**

- Your most recent declarations page.
- If claims are noted on the application, include a 10 years' loss from your current and prior insurance companies, and complete the Claim Information form.
- Additional Supplements as indicated throughout the application
- Curriculum Vitae (CV) if available

## A. AGENCY INFORMATION

Agency Name:_____ Agency Contact: _____

Address: _____
Street City State Zip

Office Phone: _____ Email Address: _____
Your email address will never be sold. It will be used to send you important messages.

## B. APPLICANT INFORMATION

Name: _____
First Middle Last

☐ Female ☐ Male Social Security No. (last 4 digits) _____ Date of Birth: _____
MO/DAY/YR

Office Phone: _____ Office Fax: _____

Email Address: _____ Cell Phone: _____
Your email address will never be sold. It will be used to send you important messages.

Primary Practice Address:

_____ _____% of Practice
Street City State Zip County

Additional Practice Location(s):

_____ _____% of Practice
Street City State Zip County

_____ _____% of Practice
Street City State Zip County

_____ _____% of Practice
Street City State Zip County

_____ _____% of Practice
Street City State Zip County **(All locations must total 100%)**

Mailing/Billing Address: ☐ Primary Practice Address
☐ Other: _____
Street City State Zip

**IF MORE ROOM IS NEEDED FOR PRACTICE LOCATIONS, PLEASE USE A SEPARATE PIECE OF PAPER.**

## C. COVERAGE INFORMATION

1. Effective date desired:_____(policy issued annually)
   MO/DAY/YR

2. Select requested coverage:

☐ CLAIMS-MADE COVERAGE ***with*** PRIOR ACTS

Desired Retroactive Date:_____
MO/DAY/YR

*The retroactive date is the date first continuously insured under a Claims-Made policy. Please contact your agent should you have any questions pertaining to Claims-Made coverage or the need for Prior Acts coverage.*

☐ OCCURRENCE

*I realize that if I switch from a Claims-Made to an Occurrence policy, my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's claims-made policy. I understand the policy I am purchasing will not provide prior acts coverage.*

☐ CLAIMS-MADE COVERAGE ***without*** PRIOR ACTS (select one below)

- ☐ Expiring Occurrence Coverage
- ☐ An extended reporting endorsement **has** been purchased
- ☐ An extended reporting endorsement **has not** been purchased

*I realize that my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's claims-made policy. I understand the policy I am purchasing will not provide prior acts coverage.*

3. Please indicate the limits of liability requested for coverage or a quote:
   *(Not all limits may be available in all states. Additional limit options available in IN, NY, and VA.)*

☐ $100,000/$300,000 ☐ $250,000/$750,000 ☐ $1,100,000/$3,000,000
☐ $200,000/$600,000 ☐ $500,000/$1,000,000 ☐ $2,000,000/$4,000,000

4. Please provide information on each professional liability insurer you have had for the last 10 years.
   *Please provide this information in chronological order:*

| Dates | Insurer | Coverage Type | Tail Coverage Purchased? | Any Claims? |
|---|---|---|---|---|
| | | ☐Occurrence ☐Claims-Made | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Occurrence ☐Claims-Made | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Occurrence ☐Claims-Made | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Occurrence ☐Claims-Made | ☐Yes ☐No | ☐Yes ☐No |
| | | ☐Occurrence ☐Claims-Made | ☐Yes ☐No | ☐Yes ☐No |

**PLEASE ATTACH A COPY OF YOUR DECLARATIONS PAGE FROM YOUR CURRENT OR PREVIOUS PRIMARY INSURER.**

5. Number of hours per week you practice dentistry: .....____hrs.
6. Will you perform activities that will be covered by another professional liability policy? .....☐ Yes ☐ No
   *If yes, please attach a copy of your declarations page, a description of these activities and the practice name and location.*
7. Will you be participating in a state-operated patient's compensation fund? *(Indiana only.)*.....☐ Yes ☐ No
8. Are you now practicing, or have you ever practiced without professional liability insurance?.....☐ Yes ☐ No
9. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? *(Missouri residents, skip this question.)* .....☐ Yes ☐ No
   *Nevada residents: Please state the reasons for any prior declination, failure to renew, conditional renewal restriction, or cancellation:* _____

**IF YOU ANSWERED YES TO QUESTIONS 8 OR 9 ABOVE, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.**

## D. EDUCATION

1. School of Graduation: _____
   Name State Country

   Degree (DMD, DDS, BDS): _____ Graduation Date: _____
   MO/DAY/YR

2. Clinical Based Training, Residency or Fellowship (facility, state):

   _____
   Name State Country

   Specialty Type: _____ Date Completed: _____
   MO/DAY/YR

   Additional Clinical Based Training, Residency or Fellowship (facility, state):

   _____
   Name State Country

   Specialty Type: _____ Date Completed: _____
   MO/DAY/YR

3. Have you participated in any continuing dental education within the last two years? ☐ Yes ☐ No
   *If yes, how many credit hours?* _____ hrs.

4. Have you completed any risk management/loss prevention courses in the past 12 months? ☐ Yes ☐ No
   *If yes, please attach a copy of any Certificates of Completion.*

**IF YOU HAVE A CURRICULUM VITAE (CV), PLEASE ATTACH TO THIS APPLICATION.**

## E. PRACTICE LOCATION AND LICENSE INFORMATION

1. Please list all states in which you currently hold or have held a license:

   State: _____ License No.: _____ _____% of Practice
   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending

   State: _____ License No.: _____ _____% of Practice
   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending

   State: _____ License No.: _____ _____% of Practice
   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending
   (All locations must total 100%)

2. DEA License? ☐ Yes ☐ No

3. All practice addresses for past 10 years (name of practice, location, dates worked):

| Name of Practice | City/State | Dates Worked (MO/YR to MO/YR) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## F. PRACTICE ORGANIZATION INFORMATION

1. Do you practice as: ☐ Employee ☐ Solo Corporation ☐ Partner in Partnership
   ☐ Independent Contractor ☐ Solo Unincorporated ☐ Shareholder in a Professional Corporation

   *If you are an Employee or Independent Contractor,*
   *Name of Employer/Dental Office:* _____

   *If you are practicing as a Solo Corporation, Partnership or Corporation, do you want professional liability coverage for this entity?* ☐ Yes ☐ No

   *If yes, please complete the Professional Liability Entity Application.*

2. Do you operate or work for a mobile dental practice? ☐ Yes ☐ No

   *If yes, complete the Mobile Dentistry Supplement Form.*

3. What percentage of your practice revenue comes from government programs (Medicare/Medicaid)? _____ %

## G. PRACTICE ACTIVITIES

1. Please indicate your primary specialty:
   ☐ General Dentistry ☐ Oral & Maxillofacial Radiology ☐ Pediatric Dentistry
   ☐ Dental Anesthesiologist ☐ Oral & Maxillofacial Surgery ☐ Periodontics
   ☐ Endodontics ☐ Orthodontics ☐ Prosthodontics
   ☐ Oral & Maxillofacial Pathology ☐ Other: _____

2. Please indicate which of the following procedures you perform and your level of training:

   a. **Sinus Lifts:**
   What percentage of your practice does this procedure make up? _____ %
   Number performed annually: _____
   What percentage are direct sinus augmentation (lateral) technique? _____ %
   What percentage are indirect sinus augmentation (osteotome) technique? _____ %
   What type of informed consent is obtained for sinus lifts? ☐ Written ☐ Oral ☐ None
   What year did you start performing sinus lifts? _____
   *Have you completed any additional sinus lift training courses or designations outside of dental school? ☐ Yes ☐ No

   b. **Dental Implants:**
   What percentage of your practice does this procedure make up? _____ %
   Number performed annually: _____
   What percentage of those dental implants are restoring existing implants? _____ %
   What percentage are placing new implants? _____ %
   What percentage are mini implants? _____ %
   What type of informed consent is obtained for dental implants? ☐ Written ☐ Oral ☐ None
   What year did you start performing dental implants? _____
   *Have you completed any additional dental implant training courses or designations outside of dental school? ☐ Yes ☐ No

   c. **Third Molar Extractions:**
   What percentage of your practice does this procedure make up? _____ %
   Number performed annually: _____
   What percentage are partially impacted? _____ %
   What percentage are fully impacted? _____ %
   What type of informed consent is obtained for third molar extractions? ☐ Written ☐ Oral ☐ None
   What year did you start performing third molar extractions? _____
   *Have you completed any additional third molar extraction training courses or designations outside of dental school? ☐ Yes ☐ No

## G. PRACTICE ACTIVITIES (continued)

d. **Botox and/or Cosmetic Fillers:**

What percentage of your practice does this procedure make up? _____ %

Number performed annually: _____

What type of informed consent is obtained for Botox and/or cosmetic fillers? ☐ Written ☐ Oral ☐ None

*What Botox/cosmetic filler training, courses, or designations have you completed? _____

***Note: Certificates of completion proving 16 hours of PACE or CERP approved coursework are required.***

e. **Sleep Apnea**

Do you perform? ☐ Yes ☐ No

If you perform sleep apnea therapy, do you treat only after referral from a physician? ☐ Yes ☐ No

3. Do you use cone beam computed tomography (CBCT) in your practice? ☐ Yes ☐ No

*If yes, what percentage of time do you use (CBCT) prior to completing:*

*Dental Implants* _____ %

*Third Molar Extractions* _____ %

4. Do you utilize any of the following anesthesia or sedation types in your practice?

a. Local anesthesia or inhalation sedation ($N_2O$) ☐ Yes ☐ No

b. Single dose or oral sedation ☐ Yes ☐ No

c. Multi-dose oral sedation ☐ Yes ☐ No

d. Intravenous conscious sedation (IV)/Intramuscular sedation (IM) ☐ Yes ☐ No

Who administers the IV/IM? _____

How many times per year do you administer IV/IM? _____

e. General anesthesia, including deep sedation ☐ Yes ☐ No

Who administers the general anesthesia? _____

How many times per year do you treat patients under general anesthesia? _____

5. Where is the sedation and/or anesthesia noted above performed?

☐ Dental Office ☐ Hospital ☐ Licensed Surgical Center (licensed by what agency?) _____

Other (please explain): _____

6. What type of informed consent is obtained for the sedation and/or anesthesia noted above? ☐ Written ☐ Oral ☐ None

7. How often do you update health histories?

☐ Every Visit ☐ Every 3 months ☐ Every 6 months ☐ Every 12 months ☐ Other: _____

8. Have you ever been audited for OSHA compliance? ☐ Yes ☐ No

*If yes, what was the date of audit and outcome?* _____

***Please provide certificates of completion for training and/or designations for any of the procedures asked in question 2.**

## H. PROFESSIONAL INFORMATION

1. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No

*If yes, what percentage of your practice is devoted to these activities?* _____ %

*If yes, where are professional services rendered?* _____

2. Do you review treatment or provide professional services to patients in a nursing home or skilled care facility? ☐ Yes ☐ No

*If yes, what percentage of your practice time is dedicated to these services?* _____ %

*If yes, where are professional services rendered?* _____

3. Do you participate in any dental research, clinical trials or off-label use of drugs or devices? ☐ Yes ☐ No

*If yes, please attach copies of any protocols and informed consent documents.*

## H. PROFESSIONAL INFORMATION (continued)

4. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than minor traffic offenses? ☐ Yes ☐ No
5. Have you ever had your dental license, hospital privileges, DEA license, or reimbursement privileges refused, denied, revoked, suspended, investigated, restricted, subject to reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No
6. Have any complaints or actions been brought against you alleging sexual misconduct? ☐ Yes ☐ No
7. Have you incurred or become aware of having a condition that impairs your ability to practice dentistry to any degree? (i.e., convulsive disorders; mental illness; multiple sclerosis; rheumatoid arthritis; addiction to alcohol, narcotics, or other controlled substances; etc.) ☐ Yes ☐ No
8. Do you use a collection agency which has the authority to file collection suits without your knowledge? ☐ Yes ☐ No

**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.**

## I. LOSS INFORMATION

1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services?* ☐ Yes ☐ No

   *If yes, please indicate the number of each:*

   *Pending suits* _____

   *Closed claims* _____

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:

   Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient? ☐ Yes ☐ No

   A letter from an attorney regarding your treatment of a patient? ☐ Yes ☐ No

   A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No

   Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? ☐ Yes ☐ No

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier? ☐ Yes ☐ No ☐ N/A

   *If yes, please attach a current loss run for each carrier, as appropriate.*

   *If no, please explain why these circumstances were not reported:* _____

* *For the purposes of this section the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.*

**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.**

## J. SIGNATURE REQUIRED

# DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM NCMIC.

**Fraud Warning and State Specific Disclosures—I acknowledge the applicable fraud warning and state disclosure as shown on the State Specific Notices page.**

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that NCMIC Insurance Company (NCMIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by NCMIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by NCMIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to NCMIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by NCMIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify NCMIC of any changes in my practice of dentistry within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state dental license, DEA license or any hospital privileges;
- Any mental or physical condition, that materially impairs my ability to practice dentistry, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Malpractice insurance is offered through PSIC RPG Association. Coverage is underwritten by NCMIC Insurance Company.

| | |
|---|---|
| Signature | Date |
| Signature of Agent (Please Print Full Name) | Date |

PSIC | RPG Association

**Mail to:**
14001 University Avenue
Clive, Iowa 50325-8258

**Questions:**
Phone: 800-864-8026
Fax: 800-600-8170

**Email:** dentalsubmissions@ncmic.com

## K. STATE SPECIFIC NOTICES

# PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**FOR RESIDENTS OF ALL STATES EXCEPT Colorado, Maryland, New York, New Jersey, Oregon, Pennsylvania, Tennessee, Virginia and Washington-- General Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

**Colorado Fraud Warning:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Maryland Fraud Warning:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey Fraud Warning:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New York Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning an fact material thereto, omits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (11 NYCRR 86.4(a)) (Parallel citation Regulation 95)

**Ohio Fraud Warning:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oregon Fraud Warning:** Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

**Pennsylvania Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Tennessee Fraud Warning:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Virginia Fraud Warning:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Washington Fraud Warning:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**North Dakota Defense Expenses within Limits of Liability:** It is acknowledged that the coverage listed in the Network Security & Privacy Proceeding Endorsement has limits of liability which may be reduced or completely eliminated by payments for legal defense costs and claims expenses.

**Minnesota Notice Concerning Policyholder Rights in an Insolvency under the Minnesota Insurance Guaranty Association Law:** The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance to you will receive the protection for which you purchased the policy. If you insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty associations limits, you will only have the assets if any, of the insolvent insurer to satisfy your claim. Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association located at 7600 Parklawn Avenue Suite 460, Edina, MN 55435. The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to $300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Fuds to pay claims may not be immediately available. The guaranty association assess insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment. THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION. THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE POLICES ARE REQUIRED TO PROVIDE THIS NOTICE.