PSIC | RPG Association

Dental Anesthesia Supplement

A. APPLICANT INFORMATION

Dentist's Name ____
First Middle Last

Office Phone: ______________________ Office Fax: ______________________

Cell Phone: ______________________ Email Address: ______________________

Your email address will never be sold. It will be used to send you important messages.

B. PRACTICE ACTIVITIES

1. General Anesthesia (CPT/CDT code D09220):
   - Please indicate who administers general anesthesia:
     - ❑ I do
     - ❑ Dentist Anesthesiologist
     - ❑ Nurse Anesthetist/CRNA
     - ❑ Oral Surgeon
     - ❑ MD/DO Anesthesiologist
     - ❑ Other (please explain): ______________________
   - Where is general anesthesia performed?
     - ❑ In Office
     - ❑ Hospital
     - ❑ Licensed Surgical Center
     - ❑ Other (please explain): ______________________
2. How often do you treat patients under general anesthesia? ______________________
3. If general anesthesia is performed at a location other than a hospital, how often do you and your staff participate in simulated emergency training?
   - ❑ Every 3 months
   - ❑ Every 6 months
   - ❑ Every 12 months

   Other (please explain): ______________________
4. Are you or the individual administering the general anesthesia certified in one or more of the following? .... ❑ Yes ❑ No

   If yes, please indicate:

   ❑ CPR ❑ ACLS ❑ ATLS ❑ PALS
5. Do you utilize the following equipment? .... ❑ Yes ❑ No

   If yes, please check all that apply:

   - ❑ Oral and Nasopharngeal Airways
   - ❑ Pulse Oximeter
   - ❑ Full Face Mask Resuscitator
   - ❑ CO2 Monitor
   - ❑ Endotracheal Tubes (adult/child size)
   - ❑ Internal/External Temperature Monitor
   - ❑ Laryngoscope
   - ❑ Portable Suction
   - ❑ Direct Current Defibrillator
   - ❑ Capnography
   - ❑ Tracheostomy/Coniotomy Equipment
   - ❑ Auxiliary Lighting
   - ❑ Sphygmomanometer/Stethoscope
   - ❑ Emergency Pharmaceutical Kit
   - ❑ Electrocardiographic Monitoring Equipment
   - ❑ Fail safe mechanisms on anesthesia machines
6. Do all anesthesia providers who are providing anesthesia services to your patients:

   Have professional liability insurance limits equal to or greater than your policy limits? .... ❑ Yes ❑ No

   Hold a valid dental/medical license in your state of practice? .... ❑ Yes ❑ No

   If anesthesia is being provided by a CRNA, are they supervised on site by a doctor? .... ❑ Yes ❑ No

Please provide a copy of your anesthesia permit, if required by your state.

Please provide a copy of your office(s) anesthesia certification(s), if required by your state.

Please provide a license and declaration page for all anesthesia providers who are providing anesthesia to your patients.

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C. SIGNATURE REQUIRED

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

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).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to NCMIC during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

Connecticut and Nevada Residents: 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.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

______________________________	______________________________
Signature of Applicant	Date
______________________________	______________________________
Signature of Soliciting Agent (Please Print Full Name)	Agency Name

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Questions:
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