PSIC | RPG Association

Mobile Dentistry Supplement

A. APPLICANT INFORMATION

Dentist's Name: _____
First Middle Last

Name of Mobile Practice: _____

Mobile Office Phone: _____ Mobile 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. Indicate the type of locations and percentages where the mobile dentistry practice provides services:
   ☐ Schools _____ % ☐ Prisons _____ % ☐ Nursing Homes _____ %
   ☐ Other: _____ % (please explain): _____
2. List all counties and states this mobile dentistry practice will provide services to:

3. What percentage of your total practice time do you practice in a mobile dentistry setting? _____%
4. Are protocols in place to distribute a standardized information sheet for the patient/guardian which includes contact information; name of dental providers (dentists/staff); description of services rendered; and, a referral/follow up plan? ..... ☐ Yes ☐ No
   If yes, please send a copy of the protocol.
5. Is medical clearance obtained for all dental procedures? ..... ☐ Yes ☐ No
6. Are procedures limited to prophylaxis and exams? ..... ☐ Yes ☐ No
   If no, what procedures will you perform? _____
   If no, what percentage are restorative: _____ % What percentage are preventative: _____ % (Should total 100%)
7. Do you obtain an informed consent form? ..... ☐ Yes ☐ No
   If yes, please provide a copy.
8. For emergency procedures, do you have a written protocol for follow-up care? ..... ☐ Yes ☐ No
   If yes, please send a copy of the protocol.
9. Does this facility meet the physical requirements set forth by the state dental board? ..... ☐ Yes ☐ No

IF YOU ANSWERED "NO" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.

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.

C. SIGNATURE REQUIRED (continued)

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) I	Agency Name

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Clive, Iowa 50325-8258

Questions:
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