PSIC | RPG Association

Dental Professional Liability Entity Application

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. ENTITY APPLICANT INFORMATION

Name of Entity: _____

Please list any and all DBA or fictitious names: _____

Federal EIN Number:_____ Date Entity Formed: _____ MO/DAY/YR

Authorized Person: _____

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 Office Address:

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

Additional Practice Location(s):

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

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

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

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

C. PRACTICE ORGANIZATION INFORMATION

1. Will the entity be participating in a state-operated patient's compensation fund? *(Indiana domiciled only)*: ... ☐ Yes ☐ No
2. Entity Type:
   - ☐ Professional Corporation – Solo Shareholder
   - ☐ Multi-Shareholder Corporation
   - ☐ Limited Liability Company
   - ☐ Partnership
3. What type of limit is the entity seeking? ..... ☐ Shared ☐ Separate
   Exception: CT – Only Shared Limits (Sole Practitioner, no employees) and Separate Limits are available.

D. GENERAL INFORMATION

1. Does the entity use a collection agency which has the authority to file collection suits without your knowledge? ☐ Yes ☐ No
2. Is the standard of care altered based on the patient's, custodial parent's or legal guardian's ability to pay? ☐ Yes ☐ No
3. Will the entity be responsible for activities that will be covered by another professional policy? ☐ Yes ☐ No
   If yes, state practice location and insurer name? _____
4. Does the entity contract to any governmental facility? ☐ Yes ☐ No
   If yes, please explain: _____
5. If/when any new employees or independent contractors are hired, is a thorough background review completed to include verification of education, licensure status and complaints or discipline, claims history, DEA licenses, credentialing, coverage history, referrals, etc.? ☐ Yes ☐ No
6. Does the entity operate a mobile dental practice? ☐ Yes ☐ No
   If yes, please complete the Mobile Dental Supplement
7. Does the entity own or operate a dental laboratory? ☐ Yes ☐ No
   If yes, please estimate the percentage of your dental laboratory work applicable to patients other than your own: _____ %
8. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled the professional liability policy associated with this entity or any subsidiary?
   (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: _____

E. LOSS INFORMATION

11. 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: Number of pending suits: _____ *Number of 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

   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.

F. STAFFING ROSTER

Please note: 100% of the dentist owners and a minimum of 50% of the entity's employed or independent contractor dentists must be insured with NCMIC Insurance Company (NCMIC) to be eligible for this coverage.

1. Please provide names of all owners, shareholders, partners, employees and independent contractors below. If the dentists are not insured with NCMIC, please have them send a copy of their declaration page.

IF MORE ROOM IS NEEDED, PLEASE COPY THIS FORM OR USE A SEPARATE PIECE OF PAPER.

Name of Entity/Dentist Employer:

Name (First, Middle, Last)	**Degree**	**Specialty** (Refer to key below)	**Employment Type** (Refer to key below)	**Individual Status** (Refer to key below)	**NCMIC Policy #**

SPECIALTY

1. General Dentistry
2. Oral & Maxillofacial Surgery
3. Orthodontist
4. Pediatric Dentistry
5. Periodontist
6. Prosthodontist
7. Endodontist
8. Dental Anesthesiologist
9. Dental Radiologist
10. Physician
11. Other

EMPLOYMENT TYPE

S – Shareholder
P – Partner
E – Employee
IC–Independent Contractor

INDIVIDUAL STATUS

A–Current NCMIC Insured
B–Requesting Coverage From NCMIC
C–Applying For or Has Coverage Elsewhere

G. APPLICATION CHECKLIST

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

- Your most recent declarations page.
- A copy of the declaration page or COI for each dentist not insured with NCMIC.
- If claims are noted on the application, include a minimum of 10-years' loss run from your current and prior insurance companies, and complete the Claim Information Form.

PLEASE COMPLETELY FILL OUT ALL AREAS ON THE APPLICATION. IF ANY AREAS DO NOT APPLY, PLEASE STATE, "N/A."

H. 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.

H. SIGNATURE REQUIRED (continued)

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

PSIC | RPG Association

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

Email: dentalsubmissions@ncmic.com

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