PMC DENTIST PROFESSIONAL LIABILITY GROUP APPLICATION

ALGONA, IOWA 50511-0370

ENTITY/PRACTICE INFORMATION

All areas should be completed - mark **N/A** if not applicable.

ENTITY:			PHONE:
CONTACT NAME:			FAX:
BUSINESS MAILING ADDRESS: (include Street, City, State, & Zip Code)			PREFERRED CONTACT METHOD: ☐PHONE ☐EMAIL
EMAIL:			FEIN:
WEBSITE:			DATE ENTITY FORMED:
PAYMENT PLAN:	☐EFT MONTHLY ☐ANNUAL ☐FLEXIBLE ☐QUARTERLY	EFFECTIVE DATE:	EXPIRATION DATE:

PLEASE PROVIDE THE STATUS / FORMATION OF YOUR PRACTICE:

☐OTHER _____

☐UNINCORPORATED INDIVIDUAL ☐PROFESSIONAL CORPORATION (SUBCHAPTER "C") ☐LIMITED LIABILITY PARTNERSHIP (LLP)

☐UNINCORPORATED PARTNERSHIP ☐PROFESSIONAL CORPORATION (SUBCHAPTER "S") ☐LIMITED LIABILITY COMPANY (LLC)

NAME ALL MALPRACTICE CARRIERS FOR THE PAST 5 YEARS:
(Attach copy of most current Declarations Page)

ANY GAPS IN COVERAGE IN THE PAST 5 YEARS? ☐ YES ☐ NO IF **YES**, PLEASE EXPLAIN.

ARE YOU A DENTAL ASSOCIATION MEMBER? ☐ YES ☐ NO | IF **YES**, NATIONAL STATE

COVERAGE

PROFESSIONAL LIABILITY LIMITS:
(Occurrence / Aggregate)

☐ **$ 500,000 / $1,500,000** ☐ **$1,000,000 / $3,000,000** ☐ **$2,000,000 / $4,000,000**
☐ **$3,000,000 / $5,000,000** ☐ **$5,000,000 / $5,000,000** (all Dentists must carry the same limit)

COVERAGE TYPE:

☐ **CLAIMS-MADE** **RETROACTIVE DATE:** _____
The retroactive date is the date first continuously insured under a Claims-Made policy.

☐ **OCCURRENCE** (where available) ☐ **PRIOR ACTS COVERAGE** (enter Retroactive Date in space above)
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 unless selected above.

ENTITY: ☐**SHARED LIMITS* – SHARED WITH ALL DENTISTS** *(Not applicable in CT & VT)
☐**SEPARATE LIMITS**

DO YOU WISH TO WAIVE YOUR CONSENT TO SETTLE OPTION? ☐ YES ☐ NO

COVERAGE AVAILABLE UNDER THE DENTISTS PROFESSIONAL LIABILITY INSURANCE POLICY INCLUDES DENTISTS PROFESSIONAL LIABILITY AND THE ADDITIONAL SUPPLEMENTARY PAYMENTS COVERAGE LISTED HERE AND WITHIN THE SPECIFIC POLICY FORMS AND ENDORSEMENTS. THE LIMITS OF LIABILITY FOR THE SUPPLEMENTARY PAYMENTS COVERAGE MAY NOT BE INCREASED UNDER THIS PROGRAM.

SUPPLEMENTARY PAYMENTS	LIMITS
MEDICAL EXPENSES	$5,000 Each Patient $10,000 Each Insured
ADMINISTRATIVE DISCIPLINARY ACTION	$50,000 Each Individual Insured
SEXUAL MISCONDUCT OR PHYSICAL ABUSE DEFENSE EXPENSE	$1,000,000 Each Insured*
*Unless lower policy limit of $500,000 per occurrence limit is selected, then $500,000 Sexual Misconduct or Physical Abuse Defense Expense Limit applies.	
HIPAA ADMINISTRATIVE ACTION	$50,000 Each Insured

LIMITED MEDICAL WASTE EXPENSE REIMBURSEMENT COVERAGE - $25,000 LIMIT? ☐ YES ☐ NO

MEDICARE / MEDICAID BILLING FRAUD DEFENSE EXPENSE REIMBURSEMENT COVERAGE - $25,000 LIMIT? ☐ YES ☐ NO

PRACTICE INFORMATION

ARE ALL PATIENTS SCREENDED FOR ORAL CANCER? ☐ YES ☐ NO

HOW OFTEN IS PATIENT HEALTH INFORMATION UPDATED?

IS INFORMED CONSENT USED REGULARLY? ☐ YES ☐ NO IF **YES**, ☐ VERBAL ☐ WRITTEN

IF NOT CONSISTENTLY, UNDER WHAT CIRCUMSTANCES WOULD YOU USE INFORMED CONSENT?

IS INFORMED REFUSAL OF TREATMENT USED REGULARLY? ☐ YES ☐ NO

WHAT ANESTHESIA IS USED FOR MANDIBULAR BLOCKS?

IS "SLEEP DENTISTRY" PRACTICED USING TRIAZOLAM (AKA: HALCION, HYPAM, TRILAM)? ☐ YES ☐ NO

ARE ANY NON-DENTAL COSMETIC SERVICES PERFORMED? ☐ YES ☐ NO IF **YES**, PLEASE EXPLAIN.

ARE ANY NON-DENTAL COSMETIC PRODUCTS OR DEVICES, INCLUDING, BUT NOT LIMITED TO, BOTOX, JUVADERM, ETC. ADMINSTERED? ☐ YES ☐ NO IF **YES**, PLEASE EXPLAIN.

PLEASE LIST ANY HOSPITALS AT WHICH YOU CURRENTLY HAVE OR ARE APPLYING FOR PROFESSIONAL PRIVILEGES:

HOSPITAL:	HOW MANY YEARS?
HOSPITAL:	HOW MANY YEARS?
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HOSPITAL:	HOW MANY YEARS?

PRACTICE SETTING

LIST ALL **PRACTICE LOCATIONS** - USE **ADDITIONAL INFORMATION** SECTION IF NEEDED. (Include Name of Facility, Address, and % of Practice)

DOES THIS PRACTICE ACCEPT PATIENTS FROM DHS? ☐ YES ☐ NO IF **YES**, WHAT % OF PATIENTS? %

HOW MANY OF THE FOLLOWING DOES THE PRACTICE EMPLOY / CONTRACT? _____ DENTISTS _____ DENTAL HYGIENISTS _____ CERTIFIED DENTAL ASSISTANTS _____ DDS ANESTHESIOLOGISTS _____ MD ANESTHESIOLOGISTS _____ OTHER _____ NON-CERTIFIED DENTAL ASSISTANTS _____ LABORATORY TECHNICIANS _____ NURSE ANESTHETISTS _____

AVERAGE # OF PATIENTS PER WEEK PER DENTIST:	AVERAGE # OF PATIENTS PER WEEK PER HYGIENISTS:

ANESTHESIA

REGARDING ANESTHESIA, PLEASE MARK THE APPROPRIATE AREA IF YOU, AN EMPLOYEE OR INDEPENDENT CONTRACTOR TREAT PATIENTS IN THE FOLLOWING CATEGORIES:

☐ YOUR PRACTICE LIMITS ADMINISTRATION OF ANESTHESIA TO LOCAL, ORAL NON-SCHEDULED DRUGS OR NITROUS OXIDE ONLY.

☐ **CONSCIOUS SEDATION OTHER THAN NITROUS OXIDE.** A MINIMALLY DEPRESSED LEVEL OF CONSCIOUSNESS THAT RETAINS THE PATIENT'S ABILITY TO INDEPENDENTLY AND CONTINUOUSLY MAINTAIN AN AIRWAY AND RESPOND APPROPRIATELY TO PHYSICAL STIMULATION AND VERBAL COMMAND, PRODUCED BY A PHARMACOLOGIC METHOD, OR A COMBINATION THEREOF. ☐ ORAL ☐ IV / IM

☐ **GENERAL ANESTHESIA TO INDUCE DEEP SEDATION.** A CONTROLLED STATE OF DEPRESSED CONSCIOUSNESS OR UNCONSCIOUSNESS, ACCOMPANIED BY PARTIAL OR COMPLETE LOSS OF PROTECTIVE REFLEXES, INCLUDING INABILITY TO INDEPENDENTLY MAINTAIN AN AIRWAY AND RESPOND PURPOSEFULLY TO PHYSICAL STIMULATION OR VERBAL COMMAND, PRODUCED BY A PHARMACOLOGIC METHOD, OR A COMBINATION THEREOF.

IF YOU INDICATED CONSCIOUS SEDATION OR GENERAL ANESTHESIA ABOVE,

DO YOU PROVIDE ANESTHESIA FOR MEDICAL PROCEDURES OTHER THAN DENTAL SERVICES? ☐ YES ☐ NO

DO YOU PROVIDE SEDATION FOR PATIENTS OTHER THAN YOUR OWN OR IN OTHER DENTAL OFFICES? ☐ YES ☐ NO

IS PROPOFOL USED? ☐ YES ☐ NO

(IF **YES** TO ANY OF THESE QUESTIONS, PLEASE EXPLAIN IN THE **ADDITIONAL INFORMATION** SECTION)

RISK MANAGEMENT

IS THERE A WRITTEN, FORMALIZED RISK MANAGEMENT PLAN? ☐ YES ☐ NO IF YES, ATTACH A COPY.
IF YES, IS THIS PROGRAM REGULARLY REVIEWED FOR EFFECTIVENESS AND/OR CHANGES? ☐ YES ☐ NO

IS THERE AN ONGOING QUALITY ASSESSMENT OR IMPROVEMENT PLAN? ☐ YES ☐ NO

IS LICENSE RENEWAL AND CREDENTIALING VERIFICATION CONDUCTED FOR THE PROFESSIONAL STAFF? ☐ YES ☐ NO

DENTIST TURNOVER RATE:_____%

ARE EDUCATION BACKGORUNDS AND/OR ADDITIONAL TRAINING PROGRAMS CHECKED WHEN APPLICABLE? ☐ YES ☐ NO

ARE PREVIOUS EMPLOYERS AND/OR PERSONAL REFERENCE CHECKED EITHER IN WRITING OR BY TELEPHONE? ☐ YES ☐ NO

IS INFORMATION REQUIRED ON ANY PROFESSIONAL LIABILITY OR WORK-RELATED CLAIM THAT HAS PREVIOUSLY BEEN MADE AGAINST ANY INDIVIDUAL? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN THE ROLE THIS INFORMATION PLAYS IN THE HIRING PROCESS:

ADDITIONAL INFORMATION

PLEASE LIST ANY ADDITIONAL REQUIRED INFORMATION HERE. IF MORE SPACE IS NEEDED, ATTACH A NEW PAGE.

ADDITIONAL INFORMATION

DENTIST SCHEDULE - LIST ALL DENTISTS IN YOUR PRACTICE

CLASS SPECIFICATIONS (TO BE USED IN SCHEDULE BELOW)

1	GENERAL DENTIST OR SPECIALIST IN ORTHODONTIC, PEDIATRIC DENTISTRY, PERIODONTICS, PROSTHODONTICS AND ENDODONTICS WITH PROCEDURES THAT DO NOT INCLUDE THE ADMINISTRATION OF A GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS UNLESS ADMINISTERED IN A HOSPITAL OR STATE LICENSED AND REGULATED SURGICAL CENTER **AND/OR** UNCONSCIOUS SEDATION OUTSIDE OF A HOSPITAL, BUT ONLY IF THE SEDATION IS ADMINISTERED BY AN ORAL SURGEON, DENTAL OR MEDICAL ANESTHESIOLOGIST OR CRNA.
2	PERFORMING THE PROCEDURES OF PARTIALLY IMPACTED THIRD MOLAR EXTRACTIONS AND ORAL PATHOLOGY, OR IMPLANTS INVOLVING OSSEOINTEGRATION, BUT ONLY IF THE PROCEDURES DO NOT INCLUDE THE ADMINISTRATION OF A GENERAL ANESTHETIC INTENDED TO CAUSE UNCONSCIOUSNESS UNLESS ADMINISTERED IN A HOSPITAL OR STATE LICENSED AND REGULATED SURGICAL CENTER.
3	PERFORMING THE PROCEDURE OF FULLY IMPACTED THIRD MOLAR EXTRACTIONS IN ADDITION, THIS APPLIES TO DENTISTS AS DEFINED IN CLASSES 1 AND 2 WHO PERFORM DENTISTRY UTILIZING GENERAL ANESTHESIA OR DEEP SEDATION UNLESS PERFORMED IN A HOSPITAL OR STATE LICENSED AND REGULATED SURGICAL CENTER, IN WHICH CASE CLASSES 1 AND 2 WILL APPLY.
4	SPECIALIST IN DENTAL ANESTHESIOLOGY
5	SPECIALIST IN ORAL AND MAXILLOFACIAL SURGERY
6	SPECIALIST IN PAIN MANAGEMENT AND ANY DENTAL SPECIALIST PERFORMING PROCEDURES NOT OTHERWISE CLASSIFIED

WARNING: NO COVERAGE IS AFFORDED BY THIS POLICY FOR ANY DENTIST, DDS ANESTHESIOLOGIST, OR MD ANESTHESIOLOGIST WHO IS NOT SPECIFICALLY LISTED BY NAME IN THE DECLARATIONS OR AN ENDORSEMENT TO THE POLICY OR IS QUALIFIED AS A "LOCUM TENENS" UNDER THE POLICY.

DENTIST NAME	CLASS	DOB	GENDER	RETRO DATE	FT PT	LICENSE # & STATE	GRAD YEAR	# OF CLAIMS

FOR EACH CLAIM, PLEASE EXPLAIN IN THE **ADDITIONAL INFORMATION** SECTION.

SIGNATURE

IF ANY OF THE ANSWERS TO THE FOLLOWING QUESTIONS IS "**YES**", PLEASE EXPLAIN IN THE **ADDITIONAL INFORMATION** SECTION:

1. ARE YOU OR ANY OTHER DENTIST IN YOUR PRACTICE AWARE OF ANY REGULATORY INVESTIGATION, ADVERSE OUTCOME, UNSATISFIED PATIENT, REQUEST FOR MEDICAL RECORDS, SEXUAL MISCONDUCT, PHYSICAL ABUSE OR UNAUTHORIZED USE OR DISCLOSURE OF PRIVATE DENTAL OR MEDICAL INFORMATION OR ANY OTHER CIRCUMSTANCE WHICH WOULD LEAD A REASONABLE PERSON TO BELIEVE THAT A LAWSUIT, CLAIM OR CHARGE MAY BE MADE AGAINST THE APPLICANT? ☐ YES ☐ NO

HAVE YOU OR ANY OTHER DENTIST IN YOUR PRACTICE…

2. HAD THEIR LICENSE OR CERTIFICATION IN ANY JURISDICTION DENIED, SUSPENDED, REVOKED OR VOLUNTARILY SURRENDERED? ☐ YES ☐ NO
3. EVER BEEN CONVICTED OF A CRIME, OTHER THAN MINOR TRAFFIC OFFENSES? ☐ YES ☐ NO
4. HAD HIS, HER, OR ITS MEMBERSHIP IN ANY DENTAL RELATED PROFESSIONAL ORGANIZATION DENIED, SUSPENDED, REVOKED OR VOLUNTARILY SUSPENDED? ☐ YES ☐ NO
5. EVER BEEN SUBJECT TO A GOVERNMENTAL AGENCY, DENTAL OR PROFESSIONAL SOCIETY DISCIPLINARY PROCEEDING RESULTING IN REPRIMAND, CENSURE, SANCTION OR MODIFICATIONS OF THE APPLICABLE PRACTICE, EITHER VOLUNTARY OR INVOLUNTARY, OR CURRENTLY THE SUBJECT OF AN ADMINISTRATIVE PROCEEDING OR REVIEW BY SUCH AGENCY OR SOCIETY? ☐ YES ☐ NO
6. EVER HAD HOSPITAL PRIVILEGES DENIED OR RESTRICTED? ☐ YES ☐ NO
7. EVER HAD PROFESSIONAL LIABILITY INSURANCE DECLINED, CANCELLED, REFUSED RENEWAL OR ISSUED ON SPECIAL TERMS (E.G., PREMIUM SURCHARGE OR DEDUCTIBLE)? ☐ YES ☐ NO (**Missouri Applicants** – Do not answer this question.)
8. HAVE OR HAD ANY ILLNESS OR PHYSICAL DISABILITY THAT IMPAIRS OR COULD IMPAIR ABILITY TO PRACTICE DENTISTRY (E.G., ALCOHOLISM, CONVULSIVE DISORDER, HIV, MENTAL ILLNESS, MULTIPLE SCLEROSIS OR NARCOTIC ADDICTION)? ☐ YES ☐ NO
9. HAD ANY CLAIM OR SUIT BEEN BROUGHT AGAINST YOU WITHIN THE PAST 5 YEARS? ☐ YES ☐ NO
10. CHANGED PRACTICE SETTING IN THE PAST 5 YEARS? ☐ YES ☐ NO
11. PRACTICED OUT OF STATE ANYTIME IN THE PAST 5 YEARS? ☐ YES ☐ NO
12. HAD INVOLVEMENT IN THE DESIGN, MANUFACTURE OR DISTRIBUTION OF ANY DENTAL PRODUCT(S) OR WRITTEN AN INSTRUCTION MANUAL FOR PRODUCTS FOR USE BY OTHER DENTISTS? ☐ YES ☐ NO
The professional liability coverage you are applying for does not provide product liability coverage.

I HAVE COMPLETED THE DENTIST PROFESSIONAL LIABILITY APPLICATION AFTER VERIFYING THE ACCURACY OF THE INFORMATION PROVIDED ON BEHALF OF ALL APPLICANTS FOR INSURANCE AND I DECLARE AND REPRESENT THAT ALL OF THE INFORMATION PROVIDED IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I ALSO ACKNOWLEDGE A CONTINUING OBLIGATION TO REPORT TO THE COMPANY, AS SOON AS PRACTICABLE, ANY MATERIAL CHANGES IN THE REPRESENTATIONS AND STATEMENTS ABOVE, AND IN EACH SUPPLEMENTAL APPLICATION, THAT I BECOME AWARE OF AFTER SIGNING THE APPLICATION. (I ALSO UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT.)* ***Not Applicable to AK, AZ, GA & LA Applicants**

(I ALSO UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME WITH THE INTENT TO DECEIVE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT.)** ****Applicable to LA Applicants only**

IF A POLICY IS ISSUED BY THE COMPANY, IT WILL BE IN RELIANCE ON THE ACCURACY OF THE INFORMATION PROVIDED IN THIS APPLICATION. IF YOU ACCEPT THE POLICY ISSUED BY THE COMPANY, YOU AGREE THAT THE STATEMENTS IN THIS AND ANY OTHER APPLICATION SUBMITTED TO THE COMPANY ARE TRUE AND CORRECT.

CLAIMS-MADE NOTICE

IF YOU HAVE SELECTED THE CLAIMS-MADE OPTION, THE PROFESSIONAL LIABILITY COVERAGE WILL APPLY ON A "CLAIMS-MADE AND REPORTED BASIS". THE INSURING AGREEMENTS INCLUDE SPECIAL REQUIREMENTS FOR PROVIDING TIMELY, WRITTEN NOTICE TO THE COMPANY. PLEASE READ THE POLICY CAREFULLY.

IF YOU FAIL TO REPORT ANY CLAIM MADE AGAINST YOU DURING YOUR CURRENT POLICY TERM OR FAIL TO REPORT CIRCUMSTANCES WHICH MAY GIVE RISE TO A CLAIM TO YOUR CURRENT INSURANCE COMPANY BEFORE POLICY EXPIRATION, THE CLAIM MAY NOT BE COVERED.

SIGNATURE:_____ **PHONE:**_____

PRINT NAME:_____ **DATE:**_____

TITLE:_____ **PRODUCER/#:**_____

PLEASE BE ADVISED THAT THE REPRESENTATIONS MADE IN THE APPLICATION ARE INCORPORATED BY REFERENCE INTO THE POLICY IF A POLICY IS ISSUED.

AGENCY CUSTOMER ID: _____

FRAUD STATEMENTS

AGENCY		CARRIER	NAIC CODE
			13714
POLICY NUMBER	EFFECTIVE DATE	APPLICANT / NAMED INSURED	

Applicable in AL, AR, DC, LA, MD, NM, RI and WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or 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. *Applies in MD Only.

Applicable in CO
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.

Applicable in FL and OK
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)*. *Applies in FL Only.

Applicable in KS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA
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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA
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 and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____ _____
APPLICANT'S SIGNATURE DATE (MM/DD/YYYY)