



NYSIDA
Endorsed Insurance
Program



www.mlmic.com

**Application For
Dentists
Professional
Liability Insurance**

Medical Liability Mutual
Insurance Company

Home Office
Two Park Avenue
Room 2500
New York, NY 10016
1.800.683.7769

IMPORTANT NOTICE

Coverage is available to New York State Dentists, who are members of the New York State Dental Association, on either an occurrence policy form or a claims made policy form. (Please note your choice by answering question 8 below).

If you select the claims made policy form, please be aware that **NO** coverage will be extended for any incidents, occurrences or alleged wrongful acts which took place prior to the Retroactive Date stated in the policy.

Under the claims made policy form coverage is only provided for incidents that occur on or after the Retroactive Date stated in the policy and which are reported to the Company while the policy is in effect or within 60 days following termination of insurance, unless additional reporting period coverage (Optional Extended Reporting Endorsement) is purchased which would provide an unlimited time period to report covered Claims.

During the first several years, claims made premiums are lower than occurrence premiums but then they increase gradually, independent of overall rate level increases, until the claims made risk reaches maturity.

All applications are subject to prior approval. *If acceptable, coverage can be provided no earlier than the day following the postmark on the envelope containing the completed and signed application.*

General Information

1. Name: _____ Date of Birth _____
Last Middle First Month Day Year

2. Mailing Address: _____
Number & Street City/County State Zip Code

3. Please list your professional office locations and percentage (%) of patient hours at each.

Street City/County State Percentage

Street City/County State Percentage

Street City/County State Percentage

4. Home Address:

Number & Street City/County State Zip Code

5a. Principal Office Telephone Number: _____

5b. Home Telephone Number: _____

6. Social Security Number: _____

7. On what date do you wish the insurance to be effective?
 12:01 A.M. Standard Time on:

Month Day Year

8. On which basis do you wish your policy issued?

Claims Made Form or Occurrence Form.

9. Indicate by "X" what limits you wish the policy to provide:

- Each person \$ 100,000/total liability \$ 300,000
- Each person \$ 200,000/total liability \$ 600,000
- Each person \$ 500,000/total liability \$1,000,000
- Each person \$ 500,000/total liability \$1,500,000
- Each person \$1,000,000/total liability \$1,000,000
- Each person \$1,000,000/total liability \$3,000,000
- Each person \$2,000,000/total liability \$6,000,000

10a. Have you ever had professional liability insurance?

Yes No

If yes, provide the following information with respect to all past insurance coverage.

Name of Insurance Company _____ Name of Insurance Company _____

Policy Number _____ Policy Number _____

Dates of Coverage _____ Dates of Coverage _____

Limits of Liability _____ Limits of Liability _____

Type of Coverage (Occurrence or Claims Made) _____ Type of Coverage (Occurrence or Claims Made) _____

This question must be completed by all applicants who were covered on a claims made basis by their prior carrier:

10b. If your immediate past insurance coverage was written on a claims made policy form, do you intend on purchasing Optional Extended Reporting Endorsement ("Tail") coverage from your prior carrier?

Yes No

PLEASE NOTE: If you select claims made coverage with MLMIC, it will only provide protection for incidents which both occur and are reported on or after the effective date of your policy unless you secure Prior Acts "Nose" coverage from the Company. (See Question 11.)

11. Request for Prior Acts (“Nose”) Coverage

If you are requesting Prior Acts “Nose” coverage and you meet the following requirements, please insert the appropriate dates below and provide the coverage information requested.

- a. You are presently covered on a claims made basis by a New York State admitted carrier.
- b. You are not purchasing Optional Extended Reporting Endorsement “Tail” coverage from your prior carrier.
- c. There is no coverage lapse between the cancellation date of your former claims made policy and the requested effective date of your MLMIC coverage.

For what period of time are you requesting “Nose” coverage:

_____ From (Mo./Day/Yr.) _____ To (Mo./Day/Yr.) _____

A copy of the policy (or policies), including all endorsements in effect during the period for which you are requesting “Nose” coverage must accompany your application. If this information is not included, it will delay the processing of your application.

Education Information

1a. Dental school attended:

_____ Name _____ Degree _____

_____ City/State/Country _____

_____ From _____ To _____ Year Graduated _____

1b. If you are a Foreign Dental School graduate, are you certified by the State Board of Dental Examiners?

- Yes No

What United States dental school did you attend?

_____ Name _____ Degree _____

_____ City/State _____

_____ From _____ To _____ Year Graduated _____

2. Other Training

_____ Name of School/Institution _____ Name of School/Institution _____

_____ City/State/Country _____ City/State/Country _____

_____ Type of Training _____ Degree _____ Type of Training _____ Degree _____

_____ From _____ To _____ From _____ To _____

3. What professional licenses do you hold?

_____ Type of License _____ State _____ License Number _____ Date Licensed _____

_____ Type of License _____ State _____ License Number _____ Date Licensed _____

_____ Type of License _____ State _____ License Number _____ Date Licensed _____

4. Are you Board Certified?

- Yes No

If yes, name each Specialty Board:

_____ Board _____ Board _____

_____ Date Certified _____ Date Certified _____

If no, are you Board Eligible?

- Yes No

If yes, please specify:

_____ Board _____ Board _____

5a. Please list continuing education program(s), risk management course(s) and seminar(s) you have attended over the last five years. If none, state “NONE” and advise how education is upgraded.

5b. Have you satisfactorily completed a NYSDA risk management course?

- Yes No

If yes, please list most recent date and location:

_____ Date _____ Location _____

Practice Information

1a. Please list current hospital staff appointment(s), including any for which you are applying and estimate annual number of patients admitted by you:

_____ Name of Hospital _____ Estimated Number of Admissions _____

_____ Name of Hospital _____ Estimated Number of Admissions _____

1b. Would you like certification of insurance sent to this hospital(s)?

- Yes No

2. Locations where you have practiced to date:

_____ City/State/Country _____ City/State/Country _____ City/State/Country _____

_____ From _____ To _____ From _____ To _____ From _____ To _____

3a. Are you a member of NYSDA?

- Yes No

If yes, identify District affiliation:

_____ Name of District _____

If no, have you applied or are you applying for NYSDA membership?

- Yes No

If yes, and applicable, provide date of application and name of District.

_____ Date _____ District _____

What is your ADA number?

_____ ADA Number _____

3b List all other professional societies (national, state, county, other) of which you are a member:

4a. As of the effective date of this insurance, specify the nature of your practice (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Solo Practitioner | <input type="checkbox"/> Independent Contractor |
| <input type="checkbox"/> Solo Professional Corporation (P.C.) | <input type="checkbox"/> Professional Association (P.A.) |
| <input type="checkbox"/> Multi-Dentist Professional Corporation (P.C.) | <input type="checkbox"/> Partnership |
| | <input type="checkbox"/> Other (describe): |

4b. What are the total hours per week for which you require coverage from us?

Number of Hours Requiring Coverage

4c. Are you an employee of a Professional Association, Professional Corporation, Partnership or an individual dentist?

- Yes No

If yes, provide name(s) of employer(s):

Name

Name

4d. Do you practice as part of a Professional Association, Professional Corporation or Partnership?

- Yes No

If yes, provide its name(s):

Name

Name

List all members, partners, associates and all employed dentists for each entity. (Indicate insurance carrier and Limits of Liability for each member, partner or associate.)

Name insurance Company Limits of Liability

Name insurance Company Limits of Liability

Name insurance Company Limits of Liability

Name insurance Company Limits of Liability

Name insurance Company Limits of Liability

5. PLEASE NOTE: Corporation, Association or Partnership Coverage Information

The individual dentist policy issued by the Company affords coverage to a professional corporation, association or partnership named as an insured on your policy without additional premium charge. The professional corporation, association or partnership is not provided separate Limits of Liability, rather it shares the Limits of Liability with all other persons insured under your policy.

A separate additional set of Limits of Liability, not shared with other insureds, is available to a professional corporation, association or partnership composed of two or more dentists (not available to a solo corporation) for an additional premium. (Refer to the rate schedule to determine this charge.)

I have considered the options available to me as described above and *I wish to select the following coverage* for my professional corporation, association or partnership.

- Shared Limits of Liability at no additional cost to me.
 Additional Limits of Liability for which I will pay the added premium as set forth on the Company rate schedule.

I certify by my signature (below) that this is the desire of each member of my professional corporation, association or partnership and will be reflected similarly on their applications for insurance.

Signature of Applicant Title of Applicant Date

6. Indicate percentage of your time involved in the following areas of practice: (percentages must total 100%)

- | | | | |
|-----------------------------------|--------|------------------------|--------|
| (1) General Dentistry | _____% | (8) Orthodontics | _____% |
| (2) Anesthesiology* | _____% | (9) Pedodontics | _____% |
| (3) Cosmetic Dentistry | _____% | (10) Periodontics | _____% |
| (4) Endodontics | _____% | (11) Prosthodontics | _____% |
| (5) Implantology* | _____% | (12) Public Health | _____% |
| (6) Oral or Maxillofacial Surgery | _____% | (13) T.M.D.* | _____% |
| (7) Oral Pathology | _____% | (14) Other (describe): | _____% |

*Please explain procedures performed.

7. Practice Specialty Information:

7a. Do you plan to change your specialty?

- Yes No

7b. Do you extract impacted teeth?

- Yes No

7c. Do you wire jaws closed for weight control?

- Yes No

7d. Do you do full mouth rehabilitation solely for cosmetic purposes?

- Yes No

7e. Do you perform implants?

- Yes No

7f. Do you assist oral surgeons in surgery?

- Yes No

If any answer for the above is yes, please explain. (If additional space is required, please provide information on your letterhead and attach it to this application.)

8. Anesthesia Usage (Based on the definitions listed below.)

Definitions:

General Anesthesia: is a controlled state of unconsciousness accompanied by a partial or complete loss of protective reflexes, including the inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or a combination thereof.

Conscious Sedation is a depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method or combination thereof.

8a. Do you or any of your employees administer General Anesthesia to patients?

Yes No

If yes, number of patients administered General Anesthesia annually in hospital _____ In office _____.

8b. Do you or any of your employees perform procedures on patients under General Anesthesia?

Yes No

If yes, number of procedures performed annually in hospital _____ in office _____.

8c. Do you or any of your employees administer Conscious Sedation?

Yes No

If yes, 1) Percentage of patients who receive Conscious Sedation _____ %

- 2) Types of Conscious Sedation (Percentages must total 100%)
- a) intramuscular _____ %
 - b) intravenous _____ %
 - c) nitrous oxide _____ %
 - d) combination of above _____ %

3) As respects intramuscular and intravenous sedation, please provide estimated number of patients administered to annually.

	<u>Intramuscular Sedation</u>	<u>Intravenous Sedation</u>
a) number of patients in your office	_____	_____
b) number of patients in a hospital	_____	_____

9. Indicate the number of professional employees or independent contractors other than yourself, that you have in your practice. If **None**, state "**NONE**"

Category	<u>No. of Employees</u>	<u>No. of Indep. Contractors</u>
a. Oral or Maxillofacial Surgeons	_____	_____
b. Dentists Using General Anesthesia	_____	_____
c. Dentists Using IV/IM Sedation	_____	_____
d. Dentists – All Others	_____	_____
e. Dental Assistants	_____	_____
f. Nurse Anesthetists	_____	_____
g. Dental Hygienists	_____	_____
h. Technicians – X-ray	_____	_____
i. Other (describe)	_____	_____

Underwriting Information

1. Do you teach in or are you associated with a dental school?

Yes No

If yes, indicate name of school:

Name of school

2. Do you own or operate a dental clinic?

Yes No

If yes, indicate name of clinic:

Name of clinic

If applicable, name(s) of owner(s) other than yourself.

Name(s)

3. Have you signed or will you sign any contract or agreement to assume the liability of others?

Yes No

(Please be aware that you are NOT covered under this policy for the liability of others which you have assumed under a contract or agreement.)

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS (4 through 13), PLEASE PROVIDE DETAILS ON A SEPARATE SHEET(S) AND ATTACH IT TO THIS APPLICATION.

4. Do you have a drug or alcohol dependency?

Yes No

If yes, in addition to furnishing details, please provide an affidavit from the person or organization providing treatment.

5. Are you aware of any health impairment or disability that may affect your ability to perform professionally?

Yes No

6. Have you ever been convicted of a criminal offense other than a motor vehicle violation?

Yes No

7. Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or have you ever voluntarily surrendered same?

Yes No

8. Have you ever been denied a professional license, certification by a Specialty Board or membership in any professional society or association?

Yes No

9. Has any hospital or other health care facility ever restricted, suspended or revoked your privileges, or placed you on probation?

Yes No

10. Have you been investigated by any government agency, including a State Board?

Yes No

11. Have you ever voluntarily surrendered your hospital or other health care facility privileges, narcotics or professional license to avoid suspension, restriction, probation or revocation?

Yes No

12. Except for cancellation of a sponsored insurance program, has any insurance company ever declined your application, canceled, refused to renew, restricted coverage or offered professional liability insurance to you with a deductible or at higher than regular rates?

Yes No

13. Have you ever practiced without insurance?

Yes No

REMINDER: PLEASE MAKE CERTAIN YOU PROVIDE DETAILS REGARDING ALL QUESTIONS (4-13) YOU ANSWERED "YES" TO ON A SEPARATE SHEET(S) AND ATTACH IT TO THIS APPLICATION.

Loss Information

A. Claim(s)/Suit(s)

If additional space is required for Claims or Suits, describe EACH individually on your letterhead stationery using the format described below and attach it to this application.

1. Have you ever had a malpractice Claim or Suit (closed or pending) asserted against you?

Yes No

If yes, how many?

Number of Claims/Suits

For each Claim or Suit describe as follows:

1a. Name of claimant:

1b. Dates of treatment:

c. Describe facts:

1d. State allegations of malpractice:

1e. Location of treatment:

County _____ State _____

1f. Names of others involved in treatment of claimant:

1g. Name of co-defendant(s) (if applicable):

1h. Name of insurance company defending you:

i. Status of Claim or Suit:

Pending Closed

1j. Has the Claim or Suit been submitted to the District Claims Committee of NYSDA for review?

Yes No

If yes, what was the Committee's recommendation:

1k. If the case was closed, was the final disposition: A verdict against you?

Yes No

If yes, list name of co-defendant and amount of award:

Name of Co-Defendant Amount of Award \$ _____

A verdict against a co-defendant?

Yes No

If yes, list amount of award

\$ _____

A verdict against the claimant?

Yes No

A settlement prior to, or during trial?

Yes No

If yes, list settlement amount:

\$ _____

Of this sum, what was paid on your behalf?

\$ _____

Dismissed or discontinued?

Yes No

B. Event(s)/Incident(s)

1. Are you aware of any incident(s) or event(s) that may or will result in a Claim or Suit against you or your associate(s)? This will include situations such as a request for one of your patient records or any unanticipated material complication(s) related to professional services provided by you.

Yes No

If yes, please provide details including names, dates and descriptions of treatment. If more space is needed, please provide additional information on your letterhead stationery and attach it to this application.

2. Have any of these event(s) or incident(s) been reported to your prior insurance carrier(s)?

Yes No

If yes, specify the case(s) reported.

Release of Information

Note: Your signature is required following both the "Release of Information" and "Regulations 95" statements which appear below:

I hereby authorize Medical Liability Mutual Insurance Company to obtain full information from any insurance company or from any person with respect to any Claim or Suit asserted against me or event or incident pertaining to professional acts or omissions for which I could be held responsible. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

Date Signed Personal Signature of Applicant

New York State Insurance Department Regulation Declares That:

"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 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."

Date Signed Personal Signature of Applicant

THIS SECTION FOR COMPANY USE ONLY – NOT TO BE COMPLETED BY APPLICANT

EFFECTIVE DATE			EXPIRATION DATE			PREMIUM RATING			COUNTY		TYPE PRAC	RATING BASIS
MO	DAY	YR	MO	DAY	YR	CLASS	SPEC	TERR	RISK	SOCTY		
LIMITS OF LIABILITY						END. TO BE ATTACHED AT ISSUE					TERM OF DAYS	
EACH PERSON		AGGREGATE		CODE		LIMITING END NO.		OTHER:				
\$		\$										
GROUP OR PC NAME						PROF. RATING			GROUP I.D. NO.			
ENTITY TYPE	SHARED LIMIT		ADDITIONAL INSURED POL. #			PRIOR ACTS DATE		CHECKED BY:		DATE:		

BASIC COVERAGE PREMIUM \$ _____

OTHER: _____ \$ _____

Total Policy Premium \$ _____