NYSDA | MLMIC
MLMIC Insurance Company

The NYSDA-MLMIC Program for Dental Professional Liability Insurance

MLMIC Insurance Company

www.mlmic.com

NYSDA
Endorsed Insurance
Program

Application For
Dentists
Professional
Liability Insurance

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):

☐ Solo Practitioner
☐ Solo Professional Corporation (P.C.)
☐ Multi-Dentist Professional Corporation (P.C.)
☐ Independent Contractor
☐ Professional Association (P.A.)
☐ Partnership
☐ 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.

	Intramuscular Sedation	Intravenous Sedation
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	No. of Employees	No. of Indep. Contractors
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 poicy 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 MLMIC 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	RATING
MO	DAY	YR	MO	DAY	YR	CLASS	SPEC	TERR	RISK	SOCTY	PRAC	BASIS

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 $_____