MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

P.O. Box 1287, Latham, NY 12110
(800) ASK-MLMIC | MLMIC.com
New York City | Long Island | Colonie | Syracuse | Buffalo

Application for Dentists Professional Liability Insurance

www.MLMIC.com

IMPORTANT NOTICE

Coverage is available to qualifying New York State Dentists, on either an occurrence policy form or a claims made policy form. (Please note your choice 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 your application is approved, coverage can be provided no earlier than the day following our receipt of the signed and completed application.*

Answer ALL questions. An incomplete application cannot be evaluated. If a question is not applicable, state N/A.

Preliminary Questions

Are you newly licensed in New York? ☐ Yes ☐ No

Have you just completed your GPR? ☐ Yes ☐ No

Are you an Oral Surgeon? ☐ Yes ☐ No

General Information

Last Name | First Name | Middle Name | Date of Birth

License Number | NPI Number | E-Mail Address

Principal Office Phone Number | Cell Phone Number | Home Phone Number | Fax Number

Mailing Address:

Address Line 1 | Address Line 2

City | State | Zip Code | County

Home Address: Same as Mailing Address: ☐ Yes ☐ No

Address Line 1 | Address Line 2

City | State | Zip Code | County

List all professional office locations requiring coverage from us and percentage (%) of patient hours at each. MUST TOTAL 100%.

Street	City	State	Zip Code	County	% of time

Applicant Name: _____

General Information *(continued)*

Are you practicing at a location where coverage is already being provided by another carrier? ☐ Yes ☐ No
If yes, please provide a copy of the declarations page of the policy.
(Please note, coverage for this location will be excluded from this policy)

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

On which basis do you wish your policy issued? ☐ Claims Made ☐ Occurrence

Select limits of liability you wish the policy to provide:

(*Note: Only Limit Available for New Dentist Flat Rate)

- ☐ $100,000 Each Person/$300,000 Total
- ☐ $200,000 Each Person/$600,000 Total
- ☐ $500,000 Each Person/$1,000,000 Total
- ☐ $500,000 Each Person/$1,500,000 Total
- ☐ $1,000,000 Each Person/$1,000,000 Total
- ☐ $1,000,000 Each Person/$3,000,000 Total*
- ☐ $1,300,000 Each Person/$3,900,000 Total
- ☐ $2,000,000 Each Person/$6,000,000 Total

Have you ever had professional liability insurance? ☐ Yes ☐ No
If yes, provide the following information with respect to <u>all</u> past insurance coverage**.**

Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage

The following questions must be completed by all applicants who were covered on a <u>claims made</u> basis by their prior carrier:

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 Request for Prior Acts ("Nose") Coverage)

Request for Prior Acts ("Nose") Coverage

This section should only be completed if you meet the following requirements:

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

For what period of time are you requesting "Nose" coverage?

_____ From (MM/DD/YYYY): _____ To (MM/DD/YYYY):

<u>A copy of the declaration page 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</u>.

Applicant Name: _____

Education Information

Dental School Attended:

Name _____ Degree _____

City _____ State _____ Country _____ From _____ To _____ Year Graduated _____

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 _____ County _____ From _____ To _____ Year Graduated _____

Other training - including GPR and specialty training

Name of School/Institution _____

City _____ State/Country _____

From _____ To _____ Degree _____

Type of Training _____

Name of School/Institution _____

City _____ State/Country _____

From _____ To _____ Degree _____

Type of Training _____

Please enter your NYS License information:

Type of License _____ License Number _____ Date Licensed _____

Do you hold any other professional licenses? (Active or Inactive) ☐ Yes ☐ No

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

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

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

Have you attended any of the following over the past 5 years? Select all that apply.

☐ Continuing Education Program(s)
☐ Seminar(s)
☐ Risk Management Course(s)
☐ Other/None

Please attach course certificate of completion.

For Other/None, how do you meet your licensure requirements?

Applicant Name: _____

Practice Information

Do you hold any hospital staff appointments? ☐ Yes ☐ No

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

Would you like certification of insurance sent to above hospital(s)? ☐ Yes ☐ No

Have you ever practiced at any location(s) other than your current office address? ☐ Yes ☐ No

List locations where you have practiced to date:

City	State	Country	From Date	To Date

NYSDA Status: (Enter the District name or Non-Member) _____

What is your ADA number? _____

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

_____

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

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

What are the total hours per week for which you require coverage from MLMIC? ☐ 0-20 hours ☐ 21-40 hours ☐ 40+ hours

(Note: New dentists applying for Flat Rate must be full time.) Average patients per day: _____ per week: _____

Are you an employee of a Professional Partnership, Professional Limited Liability Partnership, Professional Service Corporation, Professional Limited Liability Company, or an individual dentist? ☐ Yes ☐ No

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

_____

Are you a partner of a Professional Partnership, Professional Limited Liability Partnership, a shareholder in a Professional Service Corporation or Association, or a member of a Professional Limited Liability Company? ☐ Yes ☐ No

If yes, provide name(s) of entity(s), tax identification number(s), and your relationship:

Name of entity	TID#	Relationship (partner, etc.)

List all other partners, shareholders, members, and all employed dentists for each entity *(Indicate insurance carrier and Limits of Liability for each).*

Name	Insurance Company	Limits of Liability Each Person/Total

Applicant Name: _____

Practice Information *(continued)*

PLEASE NOTE: Professional Corporation, Association or Partnership Coverage Information

The individual dentist policy issued by the Company affords coverage to your professional corporation, association or partnership named as a Qualified Professional Entity 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, may be available to a professional corporation, association or partnership composed of two or more dentists (not available to a solo corporation) for an additional premium. (Please refer to the Company for information.)

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 an additional premium (Please contact the Company for information.) A separate application is required.

I certify by checking this box 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. ☐

What is your primary practice specialty? (choose a description from the chart below) _____

Indicate the percentage of your time involved in the areas of practice shown below (percentages must total 100%):

	Specialty Area of Practice		% of time			Specialty Area of Practice		% of time
(1)	General Dentistry	☐ Yes ☐ No	%		(8)	Orthodontics	☐ Yes ☐ No	%
(2)	Anesthesiology*	☐ Yes ☐ No	%		(9)	Pediatric Dentistry	☐ Yes ☐ No	%
(3)	Cosmetic Dentistry	☐ Yes ☐ No	%		(10)	Periodontics	☐ Yes ☐ No	%
(4)	Endodontics	☐ Yes ☐ No	%		(11)	Prosthodontics	☐ Yes ☐ No	%
(5)	Implantology	☐ Yes ☐ No	%		(12)	Public Health	☐ Yes ☐ No	%
(6)	Oral or Maxillofacial Surgery	☐ Yes ☐ No	%		(13)	T.M.D.*	☐ Yes ☐ No	%
(7)	Oral Pathology	☐ Yes ☐ No	%		(14)	Other* (describe)	☐ Yes ☐ No	%

* Please explain procedures performed for anesthesiology, T.M.D. and/or Other:

Practice Specialty Information:

a. Do you plan to change your specialty? ☐ Yes ☐ No

If yes, please explain:

b. Do you extract impacted teeth? ☐ Yes ☐ No

If yes, please explain:

c. Do you wire jaws closed for weight control? ☐ Yes ☐ No

If yes, please explain:

d. Do you do full mouth rehabilitation solely for cosmetic purposes? ☐ Yes ☐ No

If yes, please explain:

Applicant Name: _____

Practice Information *(continued)*

e. Do you perform surgical placement of implants? ☐ Yes ☐ No

If yes, please complete the following:

1). How many implants do you place surgically per month? _____

2). How long have you been surgically placing implants? _____

3). Do you perform implant restoration? ☐ Yes ☐ No

If yes, how many per month? _____

4). What type of implants do you use? _____

5). Do you perform bone graft or sinus elevation surgeries? ☐ Yes ☐ No

If yes, how many per month? _____

6). Please list your training in implant surgery and the year(s) training completed:

_____

f. Do you assist oral surgeons in surgery? ☐ Yes ☐ No

If yes, please explain:

_____

Anesthesia Usage

a. Do you administer General Anesthesia or Deep Sedation to patients? ☐ Yes ☐ No

If yes, a separate application is also required. Coverage may be provided for an additional premium. Please contact the Company for information

b. Do any of your employees administer General Anesthesia or Deep Sedation to patients? ☐ Yes ☐ No

If yes, please provide name(s):

Name: _____

Name: _____

Name: _____

For all names listed above, attach copies of certification/license to provide General Anesthesia, and copy of current declarations page from professional liability carrier listing name, policy number, effective dates and limits of coverage.

(Please note that you will not be covered for your liability arising out of the acts or omissions of an employee(s) who administers General Anesthesia/Deep Sedation to patients, unless that person(s) is properly certified and licensed in NYS to do so, and insured against liability under separate valid and collectible professional liability coverage of at least the same amount as the Limits of Liability of your policy.)

c. Do you or any of your employees perform procedures on patients under General Anesthesia or Deep Sedation? ☐ Yes ☐ No

If yes, please indicate number of procedures performed annually: In hospital _____ In office _____

Applicant Name: _____

Practice Information *(continued)*

d. Do you administer Conscious (moderate) Sedation? ☐ Yes ☐ No

e. Do any of your employees administer Conscious (moderate) Sedation? ☐ Yes ☐ No

If yes, please list name(s) of persons administering Conscious (moderate) Sedation:

Name: _____

Name: _____

Name: _____

For all names listed above, please attach copies of current NYS certification to provide Conscious (moderate) Sedation, and copy of current declarations page from professional liability carrier listing name, policy number, effective dates and limits of coverage.

f. If you answered yes to questions d. and/or e. above, please answer the following:

1) Percentage of patients who receive Conscious (moderate) Sedation _____ %

2) Types of Conscious (moderate) Sedation *(Percentages must total 100%)*

a) Intramuscular _____ %

b) Intravenous/parenteral _____ %

c) Nitrous oxide _____ %

d) Enteral _____ %

e) Combination of above _____ %

3) As respects to 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		

Other than yourself, are there any professional employees or independent contractors in your practice? ☐ Yes ☐ No

If yes, indicate the number. If none, enter zero ("0").

Category	No. of Employees	No. of Independent Contractors
a) Oral Maxillofacial Surgeons		
b) Dentists Using General Anesthesia/Deep Sedation		
c) Dentists Using Conscious (moderate) Sedation		
d) Dentists - All Others		
e) Dental Assistants		
f) Nurse Anesthetists		
g) Dental Hygienists		
h) Technicians - X-Ray		
i) Other (describe below)		

Describe Other: _____

Applicant Name: _____

Underwriting Information

Please note that you will not be covered for your liability as the owner, director, trustee, proprietor, superintendent, or officer of any hospital, sanitarium, dispensary, clinic, nursing home, laboratory, or any other business enterprise. See policy exclusion

Please note that the coverage afforded for the liability of others which you have assumed under a contract agreement is limited. See policy exclusion

☐ I acknowledge I have read and agree to the terms above.

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED

Have you ever been convicted of a criminal offense other than a motor vehicle violation? ☐ Yes ☐ No
If yes, please describe:

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
If yes, please describe:

Have you ever been denied a professional license, certification by a Specialty Board or membership in any professional society or association? ☐ Yes ☐ No
If yes, please describe:

Has any hospital or other health care facility ever restricted, suspended or revoked your privileges, or placed you on probation? ☐ Yes ☐ No
If yes, please describe:

Have you been investigated by any government agency, including a State Board? ☐ Yes ☐ No
If yes, please describe:

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
If yes, please describe:

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
If yes, please describe:

Have you ever practiced without insurance? ☐ Yes ☐ No
If yes, please describe:

Applicant Name: _____

Loss Information - Claims/Suits

Do you have any claims/suits that have been reported to any previous insurance carrier(s)? ☐Yes ☐No

If yes, list ALL malpractice claims or suits asserted against you, and attach copy of claims loss history from your carrier(s).
(a) Include any claims/suits that have been closed with or without payment; and
(b) any claims/suits that are currently pending.
Do not include any claims/suits that occurred during an internship, residency or fellowship.

Incident Date	Report Date	Status	If Closed		Insurance Carrier	Claimant Name
			Date Closed	Amount Paid On Your Behalf		
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
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		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						

☐ See addendum for additional claims.

Applicant Name: _____

Loss Information - Incidents/Events

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)? ☐ Yes ☐ No

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.

If the incident/event was reported to your prior insurance carrier, list carrier name in the space provided.

Do not include any incident(s)/event(s) that occurred during an internship, residency or fellowship.

Incident Date	Report Date If Carrier Notified	Insurance Carrier	Claimant Name
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			

☐ See addendum for additional incidents.

No Consent Option

By checking yes, I hereby waive my written, unconditional consent to settle any claim and authorize MLMIC to act on my behalf to settle any claim within policy limits without first obtaining my written consent. I understand that I will receive a 5% premium credit by choosing this option. ☐ Yes ☐ No

Authorization

By selecting yes I confirm that I have reviewed and attest to the accuracy of the information provided. I also confirm that I am the insured or am acting as the Insured's Policy Administrator or authorized agent. ☐ Yes

By entering my initials below, I understand and agree that by clicking the "submit" button, (i) I am electronically signing this application, (ii) that I have reviewed the contents of the application in its entirety and understand and accept the terms therein (iii) my statements in the application are to the best of my knowledge and belief, true, correct and complete and (iv) I intend this application to be a legally binding obligation as if I had affixed my signature to the application by hand.

Applicant Initials _____

Applicant Name: ______________________________

Loss Information - Claims/Suits *(continued)*

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<tr><th rowspan="2">Incident Date</th><th rowspan="2">Report Date</th><th rowspan="2">Status</th><th colspan="2">If Closed</th><th rowspan="2">Insurance Carrier</th><th rowspan="2">Claimant Name</th></tr>
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<tr><td colspan="3">Briefly describe allegations & care/treatment:</td><td colspan="4"></td></tr>
</table>

Applicant Name: _____

Loss Information - Incidents/Events *(continued)*

Incident Date	Report Date If Carrier Notified	Insurance Carrier	Claimant Name
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			