PSIC | Professional Solutions INSURANCE COMPANY

Dental New Graduate Professional Liability Application

A. AGENCY INFORMATION

Agency Name:_____ Agent Contact: _____

Address:_____
Street City State Zip County

Office Phone:_____ Email Address: _____
Your email address will never be sold. It will be used to send you important messages.

B. APPLICANT INFORMATION

Name_____
First Middle Last

☐Female ☐Male Social Security No. (last 4 digits)_____ Date of Birth:_____
MO/DAY/YR

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

Additional Practice Location(s):

_____ _____% of Practice
Street City State Zip County

_____ _____% 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 THE LAST PAGE OF THIS APPLICATION.

C. COVERAGE INFORMATION

1. Effective date desired:_____ (policy issued annually)
MO/DAY/YR

2. Select requested coverage:
☐OCCURRENCE ☐ CLAIMS-MADE COVERAGE ***without*** PRIOR ACTS

3. Please indicate the limits of liability requested for coverage or a quote: *(Not all limits may be available in all states. Additional limit options available in VA.)*
☐$100,000/$300,000 ☐$250,000/$750,000 ☐$1,100,000/$3,000,000
☐$200,000/$600,000 ☐$500,000/$1,000,000 ☐$2,000,000/$4,000,000

4. Number of hours per week you practice dentistry: _____

5. Will you be performing activities that will be covered by another professional liability policy? ..... ☐Yes ☐No
If yes, please attach a copy of your declarations page, a description of these activities and the practice name and location.

6. Will you be participating in a state-operated patient's compensation fund? *(Indiana only)* ..... ☐Yes ☐No

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D. EDUCATION

1. School of Graduation: _____
   Name State Country
   Degree (DMD, DDS, BDS): _____ Graduation Date: _____
   MO/DAY/YR
2. Clinical Based Training, Residency or Fellowship (facility, state):
   _____
   Name State Country
   Specialty Type: _____ Date Completed: _____
   MO/DAY/YR
3. Additional Training:
   _____
   Name State Country
   Specialty Type: _____ Date Completed: _____
   MO/DAY/YR
4. Is this your first time in private practice? _____ ☐ Yes ☐ No

E. PRACTICE LOCATION AND LICENSE INFORMATION

1. Please list all states in which you currently hold or have held a license:
   State: _____ License No.: _____ Activities in this state _____%
   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending
   State: _____ License No.: _____ Activities in this state _____%
   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending
   State: _____ License No.: _____ Activities in this state _____%
   Status of License: ☐ Active ☐ Inactive ☐ Temporary ☐ Pending **(All activities must total 100%)**
2. DEA License? ..... ☐ Yes ☐ No

F. PRACTICE ORGANIZATION INFORMATION

1. Employment Status: ☐ Employee ☐ Independent Contractor ☐ Solo Unincorporated/Sole Proprietor
   ☐ Shareholder/Partner ☐ Other: _____
   If you are an Employee or Independent Contractor,
   Name of Employer/Dental Office: _____
   PSIC Policy Number of Entity/Group: _____
   If you are a shareholder/partner and desire corporation coverage, please complete the PSIC Entity Application.
2. Do you operate or work for a mobile dental practice? ..... ☐ Yes ☐ No
   If yes, complete the Mobile Dentistry Supplement Form.
3. What percentage of your revenue is from the following sources: ☐ Indemnity/Private Insurance Plans: _____%
   ☐ Government Programs (Medicare/Medicaid): _____% ☐ Other: _____% (please explain): _____
   _____

G PRACTICE ACTIVITIES

1. Please indicate your specialty:
   ☐ Dental Anesthesiologist ☐ Oral & Maxillofacial Radiology ☐ Pediatric Dentistry
   ☐ Endodontics ☐ Oral & Maxillofacial Surgery ☐ Periodontics
   ☐ General Dentistry ☐ Orthodontics ☐ Prosthodontics
   ☐ Oral & Maxillofacial Pathology ☐ Other (please explain): _____

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G. PRACTICE ACTIVITIES (continued)

2. Please indicate which of the following procedures you perform and your level of training:

	Do Not Perform	Residency/ Fellowship	16+ CE's	Dental School	Type of Informed Consent Obtained? Written, Oral or None
Sinus Lifts	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Dental Implants	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Sleep Apnea Therapy	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Partially Impacted Third Molar Extractions	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Fully Impacted Third Molar Extractions	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Oral and Maxillofacial Surgery	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Botox and/or Cosmetic Fillers	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Please provide certificates of completion confirming 16 hours of PACE– and CERP–approved course work.					
Sargenti Root Canal Therapy (N2 paste)	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)
Facial Invasive (Face Lift, Rhinoplasty, Cleft lip/palate etc.)	☐	☐	☐	☐	☐(W) ☐(O) ☐(N)

3. If you perform sinus lifts, please provide the number of sinus lift procedures performed annually: _____
   Percent of practice _____% What percent are direct _____%. What percent are indirect? _____%.
4. If you perform dental implants, please estimate the number performed annually:_____
   What percentage of those dental implants are restoring existing implants _____%
   What percentage are placing new implants _____% What percentage are mini implants _____%
   (Should total 100%)
5. If you perform sleep apnea therapy, do you treat after referral from a physician?..... ☐Yes ☐No
6. Do you use nitrous oxide in conjunction with other types of sedation noted below for patient procedures?..... ☐Yes ☐No
   If yes, the purpose is: ☐Anxiolysis/minimal sedation ☐Moderate sedation
7. Please mark below all types of sedation and/or anesthesia used in your practice:
   ☐Local Anesthesia ☐Single Dose Oral Sedation (anxiolysis/minimal)
   ☐Nitrous Oxide ☐Multi-Dose Oral Sedation (moderate)
   ☐IV/IM – Moderate Sedation ☐General Anesthesia - Deep Sedation
   ☐Other (please explain): _____
   ☐None of the above
8. Please indicate who administers the sedation and/or anesthesia noted above:
   ☐I do ☐Nurse Anesthetist/CRNA ☐Oral Surgeon
   ☐Dental Anesthesiologist ☐RN/LPN ☐MD/DO Anesthesiologist
   ☐Other (please explain): _____
9. Where is the sedation and/or anesthesia noted above performed?_____
   ☐Dental Office ☐Hospital ☐Licensed Surgical Center (licensed by what agency?) _____
   ☐Other (please explain): _____
10. If you treat patients under general anesthesia/deep sedation, please advise how often?_____
    What percentage is this of your total practice?_____%
11. Please indicate the type of consent obtained for the sedation and/or anesthesia noted above:
    ☐Written ☐Oral ☐None
12. How often do you update health histories?
    ☐Every 3 months ☐Every 6 months ☐Every 12 months
    ☐Other (please explain): _____

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H. PROFESSIONAL INFORMATION

1. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
   If yes, what percentage of your practice is devoted to these activities? _____ %
   If yes, where are professional services rendered? _____
2. Do you review treatment or provide professional services to patients in a nursing home or skilled care facility? ☐ Yes ☐ No
   If yes, what percentage of your practice time is dedicated to these services? _____ %
   If yes, where are professional services rendered? _____
3. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than minor traffic offenses? ☐ Yes ☐ No
4. Have any complaints or actions been brought against you alleging sexual misconduct? ☐ Yes ☐ No
5. Have you ever incurred or become aware of having a condition that impairs your ability to practice dentistry to any degree? (i.e. convulsive disorders; mental illness; multiple sclerosis; rheumatoid arthritis; addiction to alcohol, narcotics, or other controlled substances; etc.) ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.

I. LOSS INFORMATION

1. Do you have any knowledge of any incident that occurred that might give rise to a claim being made against you? _____ ☐ Yes ☐ No
   If yes, please explain: _____

FOR EACH INCIDENT, PLEASE COMPLETE AND ATTACH A CLAIM INFORMATION FORM.

J. SIGNATURE REQUIRED

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) 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 PSIC 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 PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, 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.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC 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 PSIC 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 PSIC during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Colorado, Maryland, New York, New Jersey, Oregon, Pennsylvania, Tennessee, Virginia and Washington: 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.

Colorado residents: 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.

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J. SIGNATURE REQUIRED (continued)

Maryland residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York 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, 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. (11 NYCRR 86.4(a)) {parallel citation Regulation 95}

New Jersey residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oregon 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, may be subject to prosecution for insurance fraud.

Pennsylvania 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Malpractice insurance is underwritten by Professional Solutions Insurance Company.

Signature of Applicant

Date

Signature of Soliciting Agent (Please Print Full Name)

Agency Name

K. DETAILS

Section/Question	Comments

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE.

PSIC | Professional Solutions INSURANCE COMPANY

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

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

Email: dentalsubmissions@psicinsurance.com

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“NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA INSURANCE GUARANTY ASSOCIATION LAW

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
7600 Parklawn Avenue Suite 460
Edina, MN 55435

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to $300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.”