PSIC | RPG Association

Dental Professional Liability Bridge Application

A. AGENCY INFORMATION

Agency Name:_____ Agency 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 A SEPARATE PIECE OF PAPER.

C. PRACTICE ACTIVITIES

1. 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
2. Please mark below all types of sedation and/or anesthesia used in your practice:
   - ☐ Local Anesthesia
   - ☐ Nitrous Oxide
   - ☐ IV/IM – Moderate Sedation
   - ☐ Single Dose Oral Sedation (anxiolysis/minimal)
   - ☐ Multi-Dose Oral Sedation (moderate)
   - ☐ General Anesthesia - Deep Sedation
   - ☐ Other (please explain): _____
   - ☐ None of the above

C. PRACTICE ACTIVITIES (continued)

3. 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): _____
4. Where is the sedation and/or anesthesia noted above performed?
   ☐ Dental Office ☐ Hospital ☐ Licensed Surgical Center (licensed by what agency?) _____
   ☐ Other (please explain): _____
5. If you treat patients under general anesthesia/deep sedation, please advise how often?_____
   What percentage is this of your total practice?_____%
6. Please indicate the type of consent obtained for the sedation and/or anesthesia noted above:
   ☐ Written ☐ Oral ☐ None
7. How often do you update health histories?
   ☐ Every 3 months ☐ Every 6 months ☐ Every 12 months
   ☐ Other (please explain): _____
8. Has there been any change in your practice, or have you added or discontinued any procedures since the completion of the attached new business application? ..... ☐ Yes ☐ No
   If yes, please explain on a separate sheet of paper.

D. PROFESSIONAL INFORMATION

1. Have you ever had your dental license, DEA license, hospital or reimbursement privileges refused, denied, revoked, suspended, investigated, restricted, subject to reprimand, placed on probation or voluntarily surrendered? ..... ☐ Yes ☐ No
2. 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

E. LOSS INFORMATION

1. Within the last 10 years, have you been involved, directly or indirectly, in a **claim** or suit arising out of the rendering or failing to render professional services?* ..... ☐ Yes ☐ No
   *If yes, please indicate the number:*_____
2. Within the last 10 years, have you become aware of any **potential claims** arising out of the rendering or failing to render professional services?..... ☐ Yes ☐ No
3. If you answered yes to either of the above questions, have any and all **claims** and **potential claims** been reported to your current or prior insurer? _____ ☐ Yes ☐ No
   *If no, please explain:*_____

** For the purposes of this section, the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you or any professional corporation or partnership.*

For the purpose of this section, the word potential claim is defined as any incident or circumstance indicating the possibility of a legal action against you or any professional corporation/partnership. (This may include, but is not limited to: a letter from an attorney or a patient requesting medical records or expressing dissatisfaction regarding your dental treatment, a patient's or family member's dissatisfaction with the outcome of a procedure, treatment, or diagnosis, or any other situation that might reasonably lead to a claim or suit.)

FOR EACH PENDING SUIT, CLOSED CLAIM AND POTENTIAL CLAIM, PLEASE COMPLETE AND ATTACH A CLAIM INFORMATION FORM.

F. APPLICATION CHECKLIST

Please remember to attach a copy of the following with the application:

- Your most recent declarations page.
- If claims are noted on the application, include a minimum of 5-years' loss run from your current and prior insurance companies, and complete the Claim Information Form.
- Your most recent malpractice insurance application. (It must be less than three years old.)

G. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM NCMIC INSURANCE COMPANY (NCMIC).

THE ABOVE STATEMENTS ARE, TO THE BEST OF MY KNOWLEDGE, THE TRUTH, AND I HAVE NOT KNOWINGLY SUPPRESSED, WITHHELD OR MISSTATED ANY MATERIAL FACT IN COMPLETING THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE.

The undersigned represents and acknowledges that all information provided including the application, its supplements, attachments and answers to any questions our underwriter asks will be relied upon by NCMIC in determining whether to insure and 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 NCMIC 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 NCMIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to NCMIC, 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 NCMIC 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 NCMIC 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 NCMIC during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

Connecticut and Nevada 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, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Florida Residents: 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.

Dental malpractice insurance is offered through PSIC RPG Association. Coverage is underwritten by NCMIC Insurance Company.

Signature of Applicant	Date
Signature of Soliciting Agent (Please Print Full Name)	Agency Name

PSIC | RPG Association

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

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

Email: dentalsubmissions@ncmic.com