Nevada Mutual Insurance Company

Dentist Professional Liability Insurance Application Form

With your completed application, you must submit the following information:

1. Current declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
3. Current business letterhead.

Nevada Mutual Insurance Company

Nevada Mutual Insurance Company Physician Application

Coverage will only become effective upon the completion of all underwriting functions and acceptance by Nevada Mutual Insurance Company.

If any space provided herein is insufficient for complete reply, please use the provided blank **COMMENTS** section on Page 10, identifying the number of the question for which you are responding.

Primary coverage limits are $1,000,000 per claim with a $3,000,000 aggregate limit. Excess limits are not offered above underlying limits of less than $1,000,000/$3,000,000.

Requested Effective Date:______________________________
Month Day Year

Requested Retroactive Date:______________________________
Month Day Year

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why in the provided **COMMENTS** section.

1. PERSONAL INFORMATION

A. Full Name of Applicant:______________________________
FIRST MIDDLE LAST DEGREE

B. Date of Birth:____________________ C. Place of Birth:____________________
mm/dd/yyyy

D. Social Security Number:______________________________

E. Home Address: ______________________________

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____
CITY STATE ZIP

F. Home Telephone :____________________ G. email Address:____________________

2. OFFICE INFORMATION

A. Principal Office Address: ______________________________

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____
CITY STATE ZIP

B. Office Phone Number: ____________________ C. Office Fax Number: ____________________

☐ Please check this box if your Principal Office Address is <u>not</u> actually located within the city limits of the city to which your mail is addressed, and indicate the city or county in which your office is located:

______________________________ ☐ CITY ☐ COUNTY

D. Secondary Office Locations (if any): ______________________________

____

____
CITY STATE ZIP

E. Secondary Office Phone Number: ______________________________

F. Secondary Office Fax Number: ______________________________

G. Preferred billing address: ☐ Principal Office ☐ Secondary Office ☐ Home

3. LICENSING AND EDUCATION INFORMATION. LIST ALL STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE

A.	STATE	LICENSE NUMBER	% OF PRACTICE	WHICH COUNTY?	MEMBER OF STATE DENTAL ASSOCIATION?
					YES ☐ NO ☐
					YES ☐ NO ☐
					YES ☐ NO ☐

A. Other professional memberships? ______________________________

B. GRADUATE EDUCATION DATA			
NAME OF SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

C. If you are a foreign school graduate, are you certified by the state board of Dental Examiners?
YES ☐ NO ☐

D. If yes, what year were you certified? __________________

E. Are you Specialty Board Certified? YES ☐ NO ☐
If yes, please provide area(s) of certification and date of certification:

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F. Describe any continuing education and risk management education you have attended in the last three years.

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4. Professional Liability Insurance History

Name of Company (current)	Policy Limits	Period of Coverage: Retroactive Date:	☐ CLAIMS-MADE ☐ OCCURRENCE
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	☐ CLAIMS-MADE ☐ OCCURRENCE
Name of Company (current)	Policy Limits	Period of Coverage: Retroactive Date:	☐ CLAIMS-MADE ☐ OCCURRENCE
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	☐ CLAIMS-MADE ☐ OCCURRENCE
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	☐ CLAIMS-MADE ☐ OCCURRENCE

A. Have you ever applied to Nevada Mutual for insurance before? YES ☐ NO ☐

B. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage? YES ☐ NO ☐

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why on pages 13-15 and/or a separate sheet.

C. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? YES ☐ NO ☐

Important: If you answered “yes” to question 4C above, please submit a complete explanation using page 10 and/or a separate sheet of paper.

Important information regarding questions 4D and 4E (including sub-questions):

1. The word "claim" as used in Questions 4D and 4E below refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer “yes” to questions 4D through 4E (including sub-questions), please complete the attached Supplementary Claims Information Form (page 11).

D. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? YES ☐ NO ☐

E. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? YES NO

i. A request for records from a patient and/or attorney related to an adverse outcome? YES ☐ NO ☐

ii. A letter from an attorney regarding your dental treatment of a patient? YES ☐ NO ☐

iii. Patient care complications resulting in unusual, significant injury? YES ☐ NO ☐

iv. Patient or family member dissatisfaction with care outcome? YES ☐ NO ☐

v. Any other circumstances that might reasonably lead to a claim or suit? YES ☐ NO ☐

vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? YES ☐ NO ☐

a. If Yes, how many?_____________ Please attach documentation of all such reports.

b. If No, please explain on Page 10

Important: If you answer "yes" to questions 4F through 4T, please provide details on page 10 and/or a separate sheet.

F. Has your license to practice dentistry or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? YES ☐ NO ☐

G. Have your privileges at a hospital or other healthcare facility ever been suspended, revoked, voluntarily surrendered, or in any way restricted? YES ☐ NO ☐

H. Have you ever failed any licensing or Board Certification examinations? YES ☐ NO ☐

I. Have you ever been refused hospital privileges? YES ☐ NO ☐

J. Have you ever appeared before a state licensing board, peer review committee or regulatory body as a result of a patient complaint or professional investigation? YES ☐ NO ☐

K. Have you ever been convicted of a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol? YES ☐ NO ☐

L. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? YES ☐ NO ☐

M. Have you ever been accused of sexual misconduct of any kind? YES ☐ NO ☐

N. Do you have any physical handicap or any chronic illness? YES ☐ NO ☐

5. RATING INFORMATION

A. Indicate percentage of practice by specialty (total must equal 100%)

Specialty	Percentage Of Practice	Specialty	Percentage Of Practice
General Dentistry		Endodontics	
Oral/Maxillofacial Surgery		Orthodontics	
Periodontics		Prosthodontics	
Pediatric Dentistry		Public Health	
Full-Time Faculty		Other	

B. Please provide an estimate of the number of the following procedures or treatments you perform in a single year.

Procedure/ Treatment	No. Performed/ year	PROCEDURE/ TREATMENT	No. Performed/ year
General Dentistry		Endodontics	
Oral/Maxillofacial Surgery		Orthodontics	
Periodontics		Prosthodontics	
Pediatric Dentistry		Public Health	
Full-Time Faculty			

C. How many hours do you practice per week? ____________________

D. Do you own or operate a dental laboratory? YES ☐ NO ☐

If yes, what percentage of the work is done only for your patients?____________%

E. Have there been any changes in your specialty, classification or practice activity within the past ten years? YES ☐ NO ☐

Important: If "yes", describe the nature of changes in specialty, classification or practice activities on Page 10 and/or a separate sheet.

6. USE OF ANESTHETICS AND ANESTHESIA

For purposes of the policy applied for the following definitions will be used:

General Anesthesia: An induced state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command.

Deep Sedation: An induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an ai rway independently and/or to respond purposefully to physical stimulation or verbal command.

A. Is your practice limited to the use of local anesthesia, oral medication and/or nitrous oxide? YES ☐ NO ☐

B. Does Your practice include treating patients under **Deep Sedation?** YES ☐ NO ☐

If yes, what percentage of patients receive Deep Sedation? ________________

Where are the procedures performed? Office ☐ Hospital or surgical Center ☐

If in Your office, who administers the anesthesia? You ☐ Other Dentist, Anesthesiologist or CRNA ☐

C. Does Your practice include treating patients under **General Anesthesia?** YES ☐ NO ☐

If yes, what percentage of patients receive General Anesthesia?_____________

Where are the procedures performed? Office ☐ Hospital or surgical Center ☐

If in Your office, who administers the anesthesia? You ☐ Other Dentist, Anesthesiologist or CRNA ☐

D. Describe what emergency training and medical equipment you have. ____________________________

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8. PRACTICE HISTORY

PLEASE LIST LOCATIONS WHERE YOU HAVE PRACTICED SINCE FIRST LICENSED		
LOCATION	DATES (MONTH/YEAR)* START	END

*EXPLAIN ANY GAPS IN PRACTICE ON PAGE 10 AND/OR A SEPARATE SHEET

9. PRACTICE ORGANIZATION

A. Coverage Desired for: (check all that apply)

☐ Solo Entity: Name____________________

☐Separate Limits ☐Shared Limits

☐ Member of a partnership or multi-shareholder corporation:
Partnership/Group Name____________________

☐Separate Limits ☐Shared Limits

☐ Other (i.e., implied partnership, corporation, etc.):

Entity Name____________________

☐Separate Limits ☐Shared Limits

B. Give the full names of all other Dentists and Oral Surgeons affiliated with any organization(s) named in Question 9A. **All Dentist/Oral Surgeon/physician members or Dentist/Oral Surgeon/physician employees must complete a separate application if organization coverage is to be provided. Use pages 10 and/or additional sheets if needed to identify other affiliated Dentists or Surgeons.**

NAME	CURRENT PROFESSIONAL LIABILITY INSURANCE CO.

10. INFORMATION ON ALLIED DENTAL CARE PROFESSIONALS

A. Indicate the number of the following types of other individuals who provide services in your office as employees:

NUMBER	POSITION	NUMBER	POSITION
	Dental Hygienists		Nurse Anesthetists
	Dental Assistant		Nurses
	Dental Technician		Lab Technician
	X-Ray Technician		Other

12. ADDITIONAL DATA

FOR YOUR PROTECTION THE FOLLOWING WARNING IS REQUIRED BY VARIOUS STATE LAWS: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or 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 may be subject to a civil and/or criminal penalties.

SPECIFIC CONSENT
TO CONDITIONS OF CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application - regardless of whether or not I am granted insurance - and for the duration of the insurance which may be issued to me:

> To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed dentist who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

______________________________________ ______________________

Applicant's Signature **Date**

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. Please read carefully.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Nevada Mutual (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals or managed care entities in which he now holds or has held staff privileges or has been otherwise credentialed, the State Board of Medical Examiners for the State of Nevada and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): ______________________________

Signature: ______________________________

Address: ______________________________

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Date: ______________________________

ADDITIONAL COMMENTS

Dentists' Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's name:____________________
2. Date reported to insurance company:____________________
3. Name of Insurance Company:____________________
4. Date of incident and your treatment:____________________
5. Allegations:____________________

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6. What is the present condition of the patient?____________________

____

____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? YES ☐ NO ☐
8. Has Medical/Dental Screening Panel Reviewed the claim? YES ☐ NO ☐
   If "Yes", attach the Panel statement of findings. If "No" expected review date? _______
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary Judgment in your favor

☐ Court outcome in your favor
- ☐ Jury Verdict
- ☐ Directed Verdict

☐ Suit settled Out-of-Court
- a. Date claim paid______________
- b. Amount paid________________
- c. Did you want to settle this claim? YES ☐ NO☐

☐ Court Outcome in favor of plaintiff
- ☐ Jury Verdict
- ☐ Directed Verdict

Amount of Loss Payment: $________

☐ Awaiting Med/Dental Screening Panel Review

☐ Awaiting mediation

☐ Awaiting court action
- a. Reserve amount: $ __________________

10. Name and address of the attorney assigned to your case:____________________

____

11. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? YES ☐ NO ☐
    If "yes", amount was $___________________.

Signature: ______________________________ Date: ____________________

Name (Printed): ______________________________