CALIFORNIA OMS DENTAL INDIVIDUAL APPLICATION

*If previously insured with Medical Protective, please provide the policy number.

Policy # _____

Please Fax or E-Mail Application: 562-928-8149/ rwalton@mikels-ins.com
If you have questions, please contact Richard Walton at 1-800-928-0431 Ext. 120

MedPro Group
a Berkshire Hathaway company

Issuing Company:
The Medical Protective Company
Fort Wayne, Indiana

ORAL AND MAXILLOFACIAL SURGEON INDIVIDUAL APPLICATION

I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Last Name _____ First Name _____ M.I. _____ Suffix _____

Date of Birth (MM/DD/YYYY) _____ National Provider Identifier (NPI) _____

E-Mail _____

Business Fax _____ Business Phone _____ Residence/Cell Phone _____

B. Practice Location(s):
(Please list principal location first. Combined percentage of practice for all locations must total 100%)

1. Primary Location:

% of Practice _____ Type of Location: □ Hospital/Licensed Surgery Center □ Office □ Residence

Location Name _____

Number and Street _____

City _____ State _____ County _____ Zip Code _____

2. Additional Location:

% of Practice _____ Type of Location: □ Hospital/Licensed Surgery Center □ Office □ Residence

Location Name _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

C. Preferred Billing and Claims Correspondence Address:

□ Location Number (From Section B. above) _____ □ Other (please enter below)

Number and Street _____ Suite _____

City _____ State _____ Zip Code _____

D. Preferred Method of Contact: □ Email □ Phone

II. EDUCATIONAL BACKGROUND

A. Have you completed a risk management education course within the last twelve (12) months? □ Yes □ No

If you answered yes, did the course provide **all** of the following? □ Yes □ No

1. A minimum of three continuing dental education (CDE) hours;
2. Sponsored by an approved national/regional dental education sponsor; and
3. Strictly adhere to a risk management (loss prevention) curriculum

B. Dental / Medical School:

Name of School _____

Degree _____ Completed From (MM/YYYY) _____ To (MM/YYYY) _____

C. Residency:
(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, Fellowships, Internships, Externships, etc.) (If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program _____

Specialty Type _____

Completed? □ Yes □ No □ Still in Training From (MM/YYYY) _____ To (MM/YYYY) _____

2. Name of Hospital/Facility/Program _____

Specialty Type _____

Completed? □ Yes □ No □ Still in Training From (MM/YYYY) _____ To (MM/YYYY) _____

III. PRACTICE INFORMATION

A. States in which you hold a license to practice dentistry:
Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

	Active	Inactive	Temporary	Pending
1. State_____ License # _____	□	□	□	□
2. State_____ License # _____	□	□	□	□

3. DEA License # _____

B. Please indicate your earliest start date at your current location(s): (MM/YYYY) _____

C. Do you have previous practice locations? □ Yes □ No

If yes, list most recent location first dating back within the past ten years.

1. Name of Practice _____

City _____ State _____ Country _____

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

2. Name of Practice _____

City _____ State _____ Country _____

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

D. In the past ten years, please explain any gaps greater than one year between practice locations. _____

_____

E. To which dental societies or associations do you belong? _____

_____

F. Please indicate the estimated average weekly hours per week, for which you require MedPro coverage: _____

IV. RATING INFORMATION

A. Please check your present specialty:

Oral & Maxillofacial Surgeon

□ Dual Degree

□ Board Certified

Date of Certification (MM/YYYY) _____

B. Please check procedures you will perform in your practice:

□ **Surgical Placement of Implant Fixtures:** _____%
Informed Consent: □ Written □ Oral □ None

□ **Partially and Fully Impacted Third Molar Extractions:** _____%
Informed Consent: □ Written □ Oral □ None

□ **Sinus Lifts**

□ **Nerve Grafts**

□ **Management of Malignant Lesions**

□ **Palatal Inserts**
Do you treat only after a physician referral? □ Yes □ No

□ **Sleep Apnea Therapy**
Do you treat only after a physician referral or with an existing polysomnogram? □ Yes □ No
If no, are you willing to implement sleep apnea therapy only with physician referral going forward? □ Yes □ No

□ **TMJ Services:** _____% Surgical ____% Non-Surgical

□ **Orthognathic Surgery**

□ **Trigger Point Injections** _____%

□ **Botox, Dermal Fillers (i.e. Injections):** _____%

□ **Skin Peels**

□ **Face Lifts**

□ **Hair Transplant**

□ **Otoplasty**

□ **Rhinoplasty**

□ **Blepharoplasty**

□ **Cleft Lip and Palate Surgery**

□ **Alternative (Holistic) Dentistry/Medicine**
Please explain _____

□ **Other**
Please explain _____

IV. RATING INFORMATION (CONTINUED)

C. Do you operate any advanced CT imaging equipment? □ Yes □ No
If yes, is the equipment used on patients other than your own? □ Yes □ No

D. Indicate the percentage of your practice devoted to the following procedures:

_____% Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)

_____% Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)

_____% Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)

_____% Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

E. Have you discontinued any procedures listed in B. or C. or D. above? □ Yes □ No

Which procedures? _____ When? (MM/DD/YYYY) _____

V. ADDITIONAL PROFESSIONAL INFORMATION

A. Do you treat non-federal prison inmates? □ Yes □ No
If yes, what percentage of your practice is devoted to treating non-federal inmates? _____%
If yes, do you have other professional liability coverage for this location? □ Yes □ No
If yes, please provide the name of the location_____

B. Do you treat or review treatment of federal prison inmates? □ Yes □ No
If yes, please explain_____
(If you are covered by other insurance for the activities in A or B of this section, please complete Section VI, Question A.)

C. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? □ Yes □ No
If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

D. Has any professional liability insurance company ever declined, refused, cancelled, or non-renewed your coverage, or have you ever had an involuntary deductible or surcharge assessed against your policy? □ Yes □ No
If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

E. Have you ever been accused of sexual misconduct of any kind? □ Yes □ No
If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

F. Have you incurred or become aware of having a condition that impairs your ability to practice your dental specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.) □ Yes □ No

If yes, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type(s) of Illness _____

Date(s) of Treatment(s): From (MM/YYYY) _____ To (MM/YYYY) _____

Treating Physician(s): Name(s) _____ Address(es) _____

G. Will you be performing activities which will be covered by another professional liability policy? □ Yes □ No

If yes, are you an: □ Employee / Independent Contractor □ Resident/Fellow □ Faculty □ Military

Practice Name _____

Location _____

Name of Insurer _____

VI. PRACTICE ORGANIZATION INFORMATION

A. Practice Organization Affiliation:

1. Name of Legal Entity: _____

   If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.):

   _____

B. Type of Organization:

- □ Standard Oral Surgery Practice
- □ Clinic Receives Governmental Immunity
- □ University—Faculty
  - □ Clinical supervision of students

    Hours per week _____
  - □ Does the institution provide professional liability coverage for you? □ Yes □ No

    If yes, please provide the name of the institution _____
- □ Hospital
- □ Imaging Facility
- □ State Licensed Surgery Center:
  - □ For use by other Doctors
  - □ Your patients only
- □ Temporary Agency
- □ Other (Please explain) _____

C. Employment Status:

- □ Employee
- □ Independent Contractor
- □ Shareholder/Partner
- □ Other (Please explain) _____

D. Please indicate the number of doctors providing services in your office:

Doctors (please exclude yourself): _____

E. Type of Legal Entity (Check only one box):

- □ Solo Incorporated
- □ Multi-Shareholder Corporation / Partnership
- □ Solo Unincorporated / Sole Proprietor
- □ Limited Liability Company

If this entity or employer is currently insured by MedPro, please provide the following information:

Policy #: _____ Group #: _____ Sub-Group #: _____ Modular #: _____

□ Other (Please explain) _____

F. Do you desire coverage for this entity? □ Yes □ No

If yes, please select the type of entity coverage desired:

- □ **Shared Limit -** Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you have no employed or contracted Dentists.
- □ **Separate Limit -** Available for all Entity/Organization Types. A separate entity application is required.

To request separate entity coverage, please contact your agent or MedPro customer service (800-4MedPro) to complete an entity application for consideration.

VII. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit.

Report Professional Liability and Malpractice-related matters. (Including, but not limited to, Board complaints etc…)

For questions B and C below, report all matters 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.

A. Are you now, or have you ever been involved in a claim or suit arising out of the rendering or failure to render professional services? □ Yes □ No

If yes, how many?_____

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes but is not limited to the following: □ Yes □ No

-Cancer -Death -Permanent Neurological Injury -Permanent Nerve Injury

If yes, how many?_____

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you? □ Yes □ No

If yes, how many?_____

VIII. COVERAGE INFORMATION

A. Coverage Desired:

□ Occurrence
□ Claims-Made coverage without Prior Acts coverage
□ Claims-Made coverage with Prior Acts coverage
□ Convertible Claims-Made coverage with Prior Acts coverage

B. Requested Coverage Effective Date:

From (MM/DD/YYYY) _____12:01 a.m. To (MM/DD/YYYY) _____12:01 a.m.

Annual policy term will begin and end on the same month and day.

C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) _____12:01 a.m.

(This date is not required for Occurrence or Claims-Made without Prior Acts policies).

D. Limits Desired: _____ Per Occurrence/Per Claim Made _____ Annual Aggregate

E. List all previous professional liability insurers in the last ten years:

1. Current Insurer _____ Current Premium_____

□ Occurrence □ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

2. Previous Insurer _____

□ Occurrence □ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

3. Previous Insurer _____

□ Occurrence □ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

F. Please explain any gaps in coverage in the past ten years. _____

G. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

□ An extended reporting endorsement (tail coverage) has been purchased.

□ An extended reporting endorsement has not been and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand the policy that I am applying for with MedPro, if offered, will not provide prior acts coverage.

Initial Here

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".

IX. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? □ Yes □ No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-800-398-6726 or by sending written notice to MedPro, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name _____

Number and Street _____ Suite _____

City _____ State _____ Zip _____ Phone Number _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

X. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

Please initial the statements below.

Mandatory: All applicants must read and initial the following:

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

XI. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments"**) for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I understand that if I cancel or terminate any coverage that may be provided by the Company, earned premium shall be computed in accordance with the standard short rate tables and procedures with a maximum penalty of up to 11%. Premium adjustments shall be made within a reasonable period of time after cancellation or termination. However, payment or tender of unearned premium shall not be a condition of cancellation.

Signature_____ Date Signed _____

Type or Print Name _____

XII. ADDITIONAL INFORMATION

Attach a separate piece of paper if additional space is needed.

MedPro Group
a Berkshire Hathaway company

Issuing Company:
The Medical Protective Company
Fort Wayne, Indiana

ORAL AND MAXILLOFACIAL SURGEON ANESTHESIA SUPPLEMENT

Applicant's Name _____

Minimal or Moderate Sedation (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

General Anesthesia (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

A. Please indicate who administers Minimal/Moderate Sedation:

□ MD/DO Anesthesiologist
□ Oral Surgeon
□ Nurse Anesthetist/CRNA
□ I do
□ Dentist Anesthesiologist
□ RN/LPN
□ Other _____

Where is Minimal/Moderate Sedation administered?

□ In a Dental Office
□ Hospital
□ Licensed TJC or AAAHC Approved Surgical Center
□ Other _____

Type of sedation performed: □ Oral □ IV/IM
Training received to perform sedation: □ CE □ Post-Grad □ Other*
Informed consent obtained: □ Written □ Oral □ None*
*Please explain_____

What percentage of your practice is devoted to this type of sedation: Oral _____% IV/IM _____ %

B. Please indicate who administers Deep Sedation/General Anesthesia:

□ MD/DO Anesthesiologist
□ Oral Surgeon
□ Nurse Anesthetist/CRNA
□ I do
□ Dentist Anesthesiologist
□ RN/LPN
□ Other _____

Where is the Deep Sedation/General Anesthesia administered?

□ In a Dental Office
□ Hospital
□ Licensed TJC or AAAHC Approved Surgical Center
□ Other _____

Informed consent obtained: □ Written □ Oral □ None, please explain_____
What percentage of your practice is devoted to this type of sedation: _____%

C. Do you administer sedation/anesthesia to other than your own patients of record? □ Yes □ No
If yes, please explain _____
What percentage of your practice is devoted to this? _____%

D. Do you accept referrals for the administration of anesthesia? □ Yes □ No
What percentage of your practice is devoted to referrals? _____%
Why do you accept referrals? _____
Do the patients referred become your patients of record? □ Yes □No*
*Please explain _____

E. If sedation is administered "In a Dental Office", are you or the individual administering the sedation a member of the American Association of Oral and Maxillofacial Surgeons or the American Society of Dentist Anesthesiologists? □ Yes □ No
If no, do you and the practice staff participate in emergency training at least every six months? □ Yes □ No
Does the individual rendering anesthesia bring his/her own ancillary staff? □ Yes □ No
If no, are you willing to implement emergency training every six months? □ Yes □ No*
*Please explain _____

F. Are you or the individual administering the sedation certified in one or more of the following? □ Yes □ No
If yes, please mark the applicable boxes: □ CPR □ ACLS □ ATLS □ PALS

G. Do you or the individual administering the sedation, utilize the following equipment? (Please "X" equipment used) Checking the box indicates this equipment will be available during all sedation procedures performed outside of a hospital, TJC or AAAHC approved facility.

Basic Airway Equipment:

□ Oral and Nasopharyngeal Airways
□ Full Face Mask Resuscitator
□ Endotracheal Tubes (adult/child size) or LMA (Laryngeal Mask Airway)
□ Laryngoscope
□ Electrocardiographic Monitoring Equipment
□ Direct Current Defibrillator
□ Tracheostomy/Coniotomy Equipment
□ Sphygmomanometer/Stethoscope
□ Pulse Oximeter
□ CO2 Monitor
□ Body Temperature Monitor
□ Portable Suction
□ Capnography
□ Auxiliary Lighting
□ Emergency Pharmaceutical Kit
□ Fail-safe mechanisms on anesthesia machines

The Medical Protective Company

DENTAL LOSS INFORMATION SUPPLEMENT

Please make copies if additional forms are needed.

Applicant's Name _____

Note: Additional documentation may be requested at the Company's discretion.

A. Is the matter related to [ ] A, [ ] B or [ ] C (if applicable) from the Loss Information Section? (Check only one)

B. Patient/Claimant Information:

_____ _____ _____

Last Name **First Name** **Age**

C. Date of treatment and/or surgery, which led, or could lead, to allegations against you: (MM/YYYY) _____

D. Date notice received (if applicable): (MM/YYYY) _____

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer? (MM/YYYY) _____

Current or former insurer name _____

If no, please explain _____

F. Name of all other doctor(s), hospital(s) or health care provider(s), if any, involved:

_____

_____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $_____

If closed,

1. Date of closing (MM/YYYY): _____
2. Was a payment made? ☐ Yes ☐ No
   a. If yes, did you consent to the settlement? ☐ Yes ☐ No
   b. Total amount of settlement or award: $_____
   c. Total amount of settlement or award paid on your behalf: $_____

H. Nature of allegations or potential allegations:

Condition Treated _____

Treatment Provided _____

Alleged Negligence _____

Alleged Injury _____

Please provide a narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:

_____

_____

_____

_____