PROFESSIONALS' INSURANCE AGENCY, INC.
2904 Eastpoint Parkway
Louisville, KY 40223
(502) 423-7201 (phone)
(502) 423-7261 (fax)
(800) 333-1774 (toll-free)

Application for Claims-Made Coverage Under the ACOMS Oral and Maxillofacial Surgeons Professional Liability Insurance Program

The applicant attests and declares that the following representations of fact are the applicant's representations and are known to and represented by the applicant to be true, and the applicant knows and intends that the insurance policy as issued will be in reliance upon the truth thereof. Any falsification of information in this application constitutes grounds for denial of insurance. The applicant further attests and declares that he/she limits dental treatment to that which falls within the scope of his/her state's Dental Practice Act; and limits the delegation of treatment tasks to dental auxiliaries as defined by his/her state's Dental Practice Act.

PLEASE PRINT OR TYPE

1. **Name of Applicant**_____
   First Name Middle Last Professional Degree

   Mailing Address_____
   Street Number P. O. Box Number

   City_____ **County**_____ **State**_____ **Zip**_____

2. **Office Address**_____
   Street Number P. O. Box Number

   City_____ **County**_____ **State**_____ **Zip**_____

3. **Coverage desired for practice in the states of:**

   State_____ % of Practice_____ State_____ % of Practice_____

   State_____ % of Practice_____ State_____ % of Practice_____

4. **Additional Practice Location(s)**_____

5. **State Dental License Number(s)**_____ **ADA Number**_____

6. **Home Address**_____
   Street Number P. O. Box Number

   City_____ **County**_____ **State**_____ **Zip**_____

7. **Office Phone**_____ **Home Phone**_____

7a. **Applicant Fax Number**_____

8. **Social Security Number**_____

9. **Date of Birth**_____ **Place of Birth**_____

10. **Effective Date Requested**_____

11. **Coverage Desired (Limits indicated are "each claim" and "aggregate.")**
CLAIMS MADE FORM ONLY:

☐ $100,000/$300,000 ☐ $250,000/$750,000 ☐ $1,000,000/$3,000,000 ☐ $5,000,000/$5,000,000
☐ $200,000/$600,000 ☐ $500,000/$1,500,000 ☐ $2,000,000/$5,000,000

12. **Please list names of professional organizations to which you belong and offices held:**

☐ American Dental Association ☐ American Society of Dental Anesthesiology (A.S.D.A.)
☐ American College of OMS (ACOMS) ☐ State Society of OMS
☐ American Association of OMS (AAOMS) ☐ Other OMSA Societies

13. **Are you board certified?** ☐ Yes ☐ No If not, are you board eligible? ☐ Yes ☐ No

14. **Do you use written informed consent documents for your procedures?** ☐ Yes ☐ No If yes, please send copies of all forms used.

15. **Are you a dental/medical school faculty member?** ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Hours per week_____
Department_____
Institution_____
Address_____

16. **What is your average monthly patient load?**_____

17. **Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?** ☐ Yes ☐ No

Are you associated with any agency or organization that engages in any king of advertising for, or solicitation of, patients? ☐ Yes ☐ No
If yes, please submit copies of ALL the advertisements.

18. **Do you practice OMS full-time?** ☐ Yes ☐ No **No. of hours per week**_____

19. **Do you practice OMS part-time?** ☐ Yes ☐ No **No. of hours per week**_____
If you are part-time, please explain why._____

20. **Professional school of graduation**_____
Country_____ **Degree**_____ **Year**_____

21. **What graduate or postgraduate courses, internships or residencies have you completed?** (Indicate type, name of institution and dates)

22. **Previous locations of practice.** (Places and dates)_____

23. **Do you limit your practice to oral surgery?** ☐ Yes ☐ No If no, what is the specialty?_____

24. **List all PPO's,HMO's or any managed care organizations in which you participate.**_____

25. **At what hospitals do you have staff membership?** (Give names and nature of privileges at each)_____

26. **Listing of all hospital and other certificate holders to include full names and addresses.** (Attach additional sheets if necessary)_____

27. Please fully explain any "YES" answer to the following in the space on the last page:

A)	Has membership in any professional association or society ever been revoked or refused?	☐ Yes	☐ No
B)	Have you ever voluntarily surrendered or had a state license to practice dentistry refused, suspended or revoked?	☐ Yes	☐ No
C)	Have you ever voluntarily surrendered or had a narcotics license refused, suspended or revoked?	☐ Yes	☐ No
D)	Have you ever been treated for alcoholism, narcotic addiction or mental illness?	☐ Yes	☐ No
E)	Have you ever been convicted of a felony? If yes, please describe the felony and provide the date in the remarks section.	☐ Yes	☐ No
F)	Have you ever been convicted of a crime or traffic violation involving drugs or alcohol?	☐ Yes	☐ No
G)	Have you ever had hospital privileges denied, suspended, revoked, restricted or modified in any way?	☐ Yes	☐ No
H)	Will you be carrying additional professional liability insurance with another company? If yes, show name of company, limits and expiration date.	☐ Yes	☐ No
I)	Is premises liability insurance carried by you or for you?	☐ Yes	☐ No
J)	Are you now in or do you plan to enter military service?	☐ Yes	☐ No
K)	Have you ever used in your practice a Proplast Viatek TMJ Implant? If yes, please attach a written explanation if all implants have been replaced and when the last implant was done.	☐ Yes	☐ No

28. Indicate number of professional assistants in each category employed by you personally or in partnership or corporation of which you are a member or a shareholder:

Surgical assistant_____ Nurse anesthetist_____ Other_____

29. Do you practice as (Check one):

- ☐ Solo – individual
- ☐ Solo corporation
- ☐ Partner in a partnership
- ☐ Shareholder in a professional corporation
- ☐ Employee of a state or federal agency
- ☐ Employee of a solo – individual
- ☐ Employee of a solo corporation
- ☐ Employee of a partnership
- ☐ Employee of a multi-shareholder corporation
- ☐ Other_____
- ☐ I practice as an independent contractor

30. A) The shareholders or partners are as follows (list yourself first):

NAME	DEGREE	POLICY NUMBER	RENEWAL DATE	CURRENT RATE CLASS

B) If you are an employee, please show your employer's name_____

C) If you, your partnership or a corporation of which you are a shareholder employ any doctors or CRNA's other than those listed in item 30.A, please complete the following:

EMPLOYEE'S NAME	DEGREE	POLICY NUMBER	RENEWAL DATE	CURRENT RATE CLASS

D) If you are a partner or a shareholder and desire corporation-partnership coverage, please indicate if coverage:

a. Should be added to the current corporation-partnership policy number_____ issued to_____
or
b. if a new policy should be issued in the name of_____
(Note: This coverage is not available unless all members are insured by the company.)

E) Do you employ any oral maxillofacial surgeons or have any independent contracting dentists? ☐ Yes ☐ No
If yes, give full details._____

31. A) Do you perform any of the following orthognathic or plastic surgical procedures?

- ☐ Plastic Surgery_____
- ☐ Orthognathic Surgery_____
- ☐ Liposuction – Number/Year_____
- ☐ Mandibular – Number/Year_____
- ☐ Rhinoplasty – Number/Year_____
- ☐ TMJ Surgery – Number/Year_____
- ☐ CO_2 laser assisted skin resurfacing and uvulopalatoplasty – Number/Year_____

B) Do you have formal training in plastic/cosmetic surgery? ☐ Yes ☐ No Please attach verification of formal training.

32. Check any boxes that describe how analgesia, sedation or anesthesia is managed for your patients:

- ☐ Local anesthesia
- ☐ Oral sedation by the use of drugs swallowed by patient. List all drugs used:_____

33. Has the nature of your practice, the type of procedures you perform or your use of anesthesia changed significantly in the past five years?

☐ Yes ☐ No

If yes, please describe:_____

34. Do you dispense and/or use any drugs or chemicals that are not approved by the American Dental Association? ☐ Yes ☐ No

Please list:_____

35. Do you dispense, for profit, any medication to your patients? ☐ Yes ☐ No

36. Do you treat dental conditions which fall outside the areas covered in your state's Dental Practice Act? ☐ Yes ☐ No

If yes, please describe:_____

37. If your expiring policy is on a claims-made basis, what is the retroactive date?_____

38. If your expiring policy is on a claims-made basis, do you with to continue the same retroactive date? ☐ Yes ☐ No

PLEASE ATTACH YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY DECLARATION PAGE.

NOTE: The Company can provide prior acts coverage. If you are currently on a claims-made policy, the Company can provide coverage which retains your retroactive date.

39. A) Are you aware of any incidents, facts or circumstances which may give rise to a claim or suit in the future? ☐ Yes ☐ No

If yes, please explain in the remarks section.

B) Have you reported each such instance to your current or prior carriers? ☐ Yes ☐ No

40. Have any claims or suits been filed against you as a result of professional services rendered or that you failed to render? ☐ Yes ☐ No

IF YES, GIVE COMPLETE DETAILS ON ATTACHED SUPPLEMENTAL CLAIMS FORMS.

41. Oral & Maxillofacial Surgery classifications.

Explanation of dental and oral surgery classifications.

PLEASE IDENTIFY WHICH OF THE FOLLOWING CLASSES BEST DESCRIBES YOUR PRACTICE.

- ☐ CLASS 2: SPECIALISTS IN ORAL AND MAXILLOFACIAL SURGERY WHO UTILIZE LOCAL OR LIGHT CONSCIOUS I.V. SEDATION IN THE OFFICE. COVERAGE IS PROVIDED SHOULD A PATIENT BE RENDERED UNCONSCIOUS UNINTENTIONALLY. NO COVERAGE IS PROVIDED FOR DENTAL IMPLANT PROCEDURES, COSMETIC PLASTIC SURGERY AND HOSPITAL ORTHOGNATHIC SURGICAL PROCEDURES. **(ONLY DENTAL AVEOLAR SURGERY IN THE HOSPITAL IS INCLUDED IN THIS CLASSIFICATION.)**
- ☐ CLASS 3: SPECIALISTS IN ORAL AND MAXILLOFACIAL SURGERY WHO UTILIZE LOCAL AND I.V. CONSCIOUS/UNCONSCIOUS SEDATION IN THE OFFICE WITHOUT INTUBATION EXCEPT FOR AN EMERGENCY. COVERAGE IS PROVIDED FOR DENTAL IMPLANT PROCEDURES AND HOSPITAL DENTAL ALVEOLAR AND ORTOGNATHIC SURGICAL PROCEDURES. NO COVERAGE IS PROVIDED FOR COSMETIC PLASTIC SURGERY PROCEDURES.
- ☐ CLASS 4: SAME AS CLASS 3 EXCEPT COVERAGE IS ALSO PROVIDED FOR ORAL AND MAXILLOFACIAL SURGEONS WHO PROVIDE GENERAL INTUBATION ANESTHESIA IN AN APPROVED OFFICE SETTING.
- ☐ CLASS 5: SAME AS CLASS 3 EXCEPT COVERAGE IS ALSO PROVIDED FOR ORAL AND MAXILLOFACIAL SURGEONS WHOSE PRACTICE INCLUDEES FACIAL (ABOVE THE NECK) SURGERY IN THE OFFICE AND HOSPITALS.

42. ☐ Parenteral Conscious Sedation – (defined as: 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.)

List all drugs used:_____

☐ Parenteral Deep Sedation – (defined as: a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including inability to respond purposefully to verbal command, produced by a pharmacologic method or non-pharmacologic method, or a combination thereof.)

List all drugs used:_____

☐ General Anesthesia – (defined as: a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.)

List all drugs used:_____

Do you act as the simultaneous surgeon and anesthetist? ☐ Never ☐ Sometimes ☐ Always

Do you use a CRNA as an anesthetist? ☐ Never ☐ Sometimes ☐ Always

Do you use a dentist anesthetist? ☐ Never ☐ Sometimes ☐ Always

43. Have you completed an ADA accredited general anesthesia program of one or more years duration? ☐ Yes ☐ No

Name of institution_____

Year(s)_____

44. Did your oral surgery training include six or more months of training in general anesthesia? ☐ Yes ☐ No

45. Have you completed an ACLS course? ☐ Yes ☐ No

Do you hold a current ACLS certificate? Expiration date_____ ☐ Yes ☐ No

If not, are you currently CPR certified? ☐ Yes ☐ No

Is any other member of your operating staff currently CPR certified? ☐ Yes ☐ No

46. Are vital signs of your patients under sedation or general anesthesia being continuously monitored? ☐ Yes ☐ No

By whom? ☐ You ☐ CRNA ☐ DDS Anesthetist ☐ Other_____

47. Which of the following methods do you use in monitoring patients? Please indicate appropriate codes based on mode of anesthesia: (S) for sedation; (G) for general anesthesia; or (B) for both

_____Manual monitoring of blood pressure and heart rate
_____Precordial stethoscope
_____Electronic/automatic monitoring of blood pressure and heart rate
_____EKG monitor
_____Pulse-oximeter
_____Other_____

48. Which of the following items do you have available for emergency treatment?

☐ Oral airway ☐ Ambu bag ☐ Endotracheal tubes/scopes
☐ Oxygen ☐ Emergency drugs

49. Do you hold a current certificate/permit to administer general anesthesia or IV sedation if required by your state? ☐ Yes ☐ No

Certificate number_____ a. ☐ Not required by my state

Date of renewal_____ b. ☐ Required by my state

It is represented to Essex Insurance Company that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated herein, should the Company evidence its acceptance of the application by issuance of a policy. I/We hereby authorize the release of claim information from any prior Insurer to Market Finders Insurance Corporation, Underwriting Manager for the Company.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force.

THIS INSURANCE IS AVAILABLE ONLY TO MEMBERS OF THE ACOMS.

APPLICABLE IN THE STATE OF NEW YORK:

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.

FRAUD WARNING:

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 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.

Signature of Applicant_____ Date_____
One signed copy will be attached to the policy, cover note or certificate, if issued.

*****SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRIWTING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.

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SUPPLEMENTAL CLAIM INFORMATION

Answer all questions completely.

(PLEASE TYPE OR PRINT)

1. **Name of claimant or plaintiff:** _____
   Last First Middle Initial

2. **Date of alleged incident:** _____

3. **Name of defense counsel:** _____

4. **Name of plaintiff's counsel:** _____

5. **Location of incident** (county and state): _____

6. **Issue or type of injury claimed – What was the objective issue contested in this claim?**
   Injury: ☐ Emotional only ☐ Cosmetic ☐ Temporary disability ☐ Permanent disability
   ☐ Death ☐ Injury with economic impact

   Treatment involved: _____

   Please state allegations filed against you by patient: _____

   At what point in the treatment provided could this incident have been avoided either by a different action on your part or help from another treating dentist? Please be candid.

7. **Were other dentists or hospitals involved as co-defendants?** ☐ Yes ☐ No
   Please list their names. _____

8. **If you were one of many defendants in this legal action and your treatment was criticized by any of the dentists involved, what were the allegations against you?** _____

9. **Name of the insurance company defending you:** _____

10. **Was claim or suit actually brought against you, merely threatened, or limited to claimant's attorney contact?** _____

11. **If suit was filed, include the court docket number, if known:** _____

12. **Disposition: What happened to the claim?**
    ☐ Abandoned (no activity over 3 years) ☐ Won by defense ☐ Judgment or verdict vs. co-defendant(s) only

    ☐ Settled or ☐ Won by claimant If so, how much was paid on your behalf? _____
    What was the reason for payment on your behalf? _____

    ☐ Open (state current status) _____
    How much has the insurance company set aside in reserve for this claim? (If known) _____

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same representations and conditions.

Signature of Applicant _____ Date _____

PHOTOCOPY THIS FORM AND SUPPLY US WITH SEPARATE INFORMATION FOR EACH CLAIM, SUIT OR INCIDENT