

**UNC SCHOOL OF DENTISTRY APPLICATION
FOR FACULTY & RESIDENT COVERAGE**

NON-ASSESSABLE CLAIMS-MADE COVERAGE

I. PERSONAL/PROFESSIONAL DATA

Please answer all questions completely. If a question does not apply to you, write "N/A". Do not leave any questions unanswered. If space is inadequate, use Comments Section or attach separate sheet

Name (last, first, middle, degree)		Date of Birth (MM/DD/YY)		
UNC SOD Department				
Primary Practice Address	City	State	Zip Code	County
Residence Address	City	State	Zip Code	County
Telephone - office ()	Fax ()		Telephone - Residence ()	
E-mail address				
Additional Practice Locations				

Desired Coverage Effective Date: _____

Desired Limits (Each Claim/Aggregate) *Choose One Option.

- \$1,000,000 / \$3,000,000
- \$2,000,000 / \$4,000,000

II. DENTAL TRAINING AND HISTORY

Please answer all questions completely. If a question does not apply to you, write "N/A". Do not leave any questions unanswered. If space is inadequate, use Comments Section or attach separate sheet.

1. Classification:
- General Dentist
 - Specialist, please describe: _____

II. DENTAL TRAINING AND HISTORY, continued

2. DENTAL EDUCATION/EXPERIENCE:

A. Dental School: Institution		State	From	To	Completed? <input type="checkbox"/> NO <input type="checkbox"/> YES
B. Residency: Institution	Specialty	State	From	To	Completed? <input type="checkbox"/> NO <input type="checkbox"/> YES
C. Fellowship: Institution	Specialty	State	From	To	Completed? <input type="checkbox"/> NO <input type="checkbox"/> YES
D. Military			From	To	
E. Public Health Service		State	From	To	
F. Moonlighting		State	From	To	
J. Private Practice		State	From	To	

3. DENTAL LICENSE, INSTRUCTOR'S LICENSE OR INTERN PERMIT INFORMATION:

State/ Type of License	License/permit number	Expiration Date	Status	% of Income
/				
/				
/				

4. **DATE AND LOCATION YOU BEGAN PRACTICING:** _____
Date City, State
5. **NUMBER OF HOURS OF CONTINUING EDUCATION COMPLETED WITHIN THE PAST YEAR:** _____ hours
6. **HAS YOUR DENTAL OR DEA LICENSE EVER BEEN VOLUNTARILY OR INVOLUNTARILY SUSPENDED, DENIED, REVOKED OR RESTRICTED IN ANY LOCATION?**
 NO YES - Explain: _____
7. **HAS YOUR BOARD CERTIFICATION EVER BEEN VOLUNTARILY OR INVOLUNTARILY SUSPENDED, DENIED, REVOKED OR RESTRICTED IN ANY STATE?**
 NO YES - Explain: _____
8. **HAVE YOU EVER BEEN DIAGNOSED WITH, OR TREATED FOR, ALCOHOLISM, DRUG ADDICTION, OR MENTAL OR PHYSICAL IMPAIRMENT?**
 NO YES - Explain: _____
9. **HAVE COMPLAINTS BEEN REGISTERED AGAINST YOU WITH ANY STATE LICENSING AUTHORITY OR HOSPITAL?**
 NO YES - Explain: _____
10. **HAVE YOU EVER BEEN CHARGED WITH ANY CRIMINAL ACTIVITY?**
 NO YES - Explain: _____
11. **HAS ANY CLAIM OR SUIT FOR ALLEGED SEXUAL MISCONDUCT EVER BEEN BROUGHT AGAINST YOU?**
 NO YES - Explain: _____
12. **HAS MEDICARE OR MEDICAID AUTHORITIES EVER BROUGHT CHARGES AGAINST YOU?**
 NO YES - Explain: _____

III. INSURANCE HISTORY

PLEASE LIST CARRIER(S) FOR PAST 10 YEARS; INCLUDING DENTAL SCHOOL & RESIDENCY IF WITHIN THAT TIME PERIOD. Please answer all questions completely. If a question does not apply to you, write "N/A". Do not leave any questions unanswered. If space is inadequate, use Comments Section or attach separate sheet

IMPORTANT:

1. IF YOU ARE A **RESIDENT ENTERING DIRECTLY FROM DENTAL SCHOOL WITH NO INDIVIDUAL COVERAGE IN YOUR PAST, ENTER YOUR DENTAL SCHOOL CARRIER'S INFORMATION IN THE FIRST COLUMN.**
2. **FACULTY MEMBERS OR RESIDENTS WHO HAVE HAD PRIVATELY HELD INSURANCE SHOULD PROVIDE ALL PRIOR CARRIERS AS REQUESTED. A LOSS RUN FROM YOUR CURRENT CARRIER(S) COVERING THE PAST 10 YEARS IS REQUIRED AND MUST BE RECEIVED WITHIN 30 DAYS OF THE EFFECTIVE DATE OF COVERAGE.**

	Current Carrier	First Prior Carrier	Second Prior Carrier	Third Prior Carrier	Fourth Prior Carrier
Insurance Company					
Coverage form	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Policy Period					
Limit of Liability Per claim/aggregate					
Deductible and amount (if applicable)	Deductible \$	Deductible \$	Deductible \$	Deductible \$	Deductible \$
Prior Acts Date					

1. IF YOU ARE CURRENTLY INSURED BY A CLAIMS-MADE POLICY, ARE YOU OBTAINING EXTENDED REPORTING ("TAIL") COVERAGE FROM YOUR CURRENT INSURANCE COMPANY?
 YES NO, – If no, please explain: _____
2. HAS YOUR INSURANCE FOR DENTAL MALPRACTICE EVER BEEN SURCHARGED, WRITTEN WITH A DEDUCTIBLE OR WRITTEN IN A NON-STANDARD MARKET?
 NO YES - Explain: _____

3. HAS YOUR INSURANCE FOR DENTAL MALPRACTICE EVER BEEN CANCELED, SUSPENDED, NON-RENEWED OR DECLINED?
 NO YES - Explain: _____
4. HAVE YOU EVER HAD PROFESSIONAL LIABILITY INSURANCE PROVIDED BY MEDICAL SECURITY INSURANCE COMPANY?
 NO YES - Explain: _____

IV. DENTAL SCHOOL PRACTICE

Please answer all questions completely. If a question does not apply to you, write "N/A". Do not leave any questions unanswered. If space is inadequate, use Comments Sheet or attach separate sheet

1. PLEASE INDICATE YOUR POSITION AT THE SCHOOL OF DENTISTRY:
 Faculty
 Resident

IV. DENTAL SCHOOL PRACTICE, continued

2. **DO YOU HAVE ANY DENTISTRY RELATED DUTIES THAT ARE INSURED BY ANOTHER COMPANY OR FOR WHICH YOU DO NOT DESIRE COVERAGE AS PART OF THE UNC SCHOOL OF DENTISTRY?** NO YES - Explain: _____

3. **DO YOU PRACTICE GENERAL DENTISTRY?** NO YES
If no, indicate specialty:

- | | | |
|--|---|---|
| <input type="checkbox"/> Oral Pathology | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Endodontics |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Periodontics |
| <input type="checkbox"/> Prosthodontics | <input type="checkbox"/> Oral & Maxillofacial Surgery | <input type="checkbox"/> Oral Facial Pain |
| <input type="checkbox"/> Dental Anesthesiology | <input type="checkbox"/> Dental Radiology | <input type="checkbox"/> Other _____ |

4. **DO YOU PRACTICE IN THE DENTAL FACULTY PRACTICE PLAN?** NO YES

5. **Do you administer any of the following types of sedation? Please check only those procedures that you perform in your practice or hospital setting. Include a copy of your Application for your Permit and your issued State Board Permit and any other related documentation of additional training obtained.**

INHALATION ANALGESIA: Nitrous Oxide Inhalation

ANXIOLYSIS: *No Permit Required

Pharmacological reduction of anxiety through the administration of a **single dose of a minor psychosedative, possibly in combination with nitrous oxide, to children or adults prior to commencement of treatment on the day of the appointment** which allows for uninterrupted interactive ability in a totally awake patient with no compromise in the ability to maintain a patent airway continuously and without assistance. Nitrous Oxide administered in addition to the minor psychosedative does not constitute multiple dosing.

MINIMAL CONSCIOUS SEDATION: *Requires Permit

Conscious sedation characterized by a minimally depressed level of consciousness, in which patient retains the ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command, provided to patients 13 years or older, by oral or rectal routes of **administration of a single pharmacological agent, in one or more doses**, not to exceed the manufacturer's maximum recommended dose, at the time of treatment, possibly in combination with nitrous oxide. Minimal conscious sedation is provided for behavioral management.

MODERATE CONSCIOUS SEDATION *Requires Permit

Conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years of older, by oral, nasal, rectal or parenteral routes (IV/IM) of administration of multiple pharmacological agents, in multiple doses, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate conscious sedation is provided for behavioral control.

MODERATE CONSCIOUS SEDATION LIMITED TO ORAL ROUTES AND NITROUS OXIDE INHALATION *Requires Permit

Conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years of older, by oral routes of administration and nitrous oxide inhalation, of **single or multiple pharmacological agents, in single or multiple doses**, within a 24 hour period. Moderate conscious sedation limited to oral routes and nitrous oxide inhalation is provided for behavioral control.

MODERATE PEDIATRIC CONSCIOUS SEDATION *Requires Permit

Conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to **patients under 13 years of age, by oral, nasal, rectal or parenteral routes** of administration of **single or multiple pharmacological agents, in single or multiple doses**, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate pediatric conscious sedation is provided for behavior control.

6. **Please check the appropriate boxes relating to the location (s) you administer conscious sedation or general anesthesia.**

- office only hospital only both not applicable

V. CLAIMS HISTORY

1. Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services?
 Yes No

2. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in claim being brought against you? Yes No
 - If you answered **Yes** to #1 or #2 above, please complete the following for each such circumstance.
 - For paid claims, please attach a copy of the National Practitioner Data Bank Submission, if available.
 - If you need more space, use comments section or attach additional sheet(s).

Patient's Name			
Date of Occurrence		Insurance Carrier	
Location of Occurrence			
Date claim reported / /	Date claim closed / /	Amount reserved \$	Amount paid \$
Full description of Allegation and Resolution:			

V. CLAIMS HISTORY, continued

Patient's Name			
Date of Occurrence		Insurance Carrier	
Location of Occurrence			
Date claim reported / /	Date claim closed / /	Amount reserved \$	Amount paid \$
Full description of Allegation and Resolution:			

VI. AUTHORIZATION AND RELEASE

I understand that this is an application and is not an insurance binder and acknowledge that the foregoing statements and answers are complete and correct to the best of my knowledge and belief. I further understand that an incorrect or incomplete response could void my protection if coverage is written as a result of this application.

I, the undersigned, authorize the release and exchange of information involving either underwriting or claims matters between present or prior insurance carriers, hospitals and other Dentists and Medical Security Insurance Company.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and Medical Security Insurance Company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

Signature of Applicant

Date

Name and Address of Agent:

Signature of Agent

Date

Please return completed application to **Medical Security Insurance Company**
Attention: Underwriting Department
P.O. Box 98028
Raleigh, NC 27624-8028

COMMENTS SECTION

QUESTION #

COMMENTS
