

MEDICAL SECURITY INSURANCE COMPANY

DENTAL PRACTITIONERS APPLICATION

CLAIMS-MADE COVERAGE

I. PERSONAL/PROFESSIONAL DATA

Name (last, first, middle, degree)		Date of Birth (MM/DD/YY)		
Clinic Name/Employer				
Primary Practice Address	City	State	Zip Code	County
Residence Address	City	State	Zip Code	County
Telephone - office ()	Fax ()		Telephone - Residence ()	
Tax I.D. Number	E-mail address		Social Security Number	
Additional Practice Locations				

Desired Policy Dates

Effective Date: _____

Prior Acts Date (Retro Date): _____

Desired Limits (Each Claim/Aggregate)

***Choose One Option.**

- \$1,000,000/\$3,000,000
- \$2,000,000/\$4,000,000
- \$3,000,000/\$3,000,000
- \$3,000,000/\$5,000,000
- \$4,000,000/\$6,000,000

- \$ 5,000,000/\$ 7,000,000
- \$ 6,000,000/\$ 8,000,000
- \$10,000,000/\$10,000,000
- \$10,000,000/\$12,000,000
- Other _____

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 Sheet or attach separate sheet.

1. **Dental Specialty:** _____ Percentage of practice: _____ %
Sub-specialty: _____ Percentage of practice: _____ %

Do you employ an Oral Surgeon or Dentist in your practice? NO YES
 If "Yes", Percentage of practice: _____ %

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. **NUMBER OF HOURS OF CONTINUING EDUCATION COMPLETED WITHIN THE PAST TWO YEARS:** _____ hours

4. **DATE AND LOCATION YOU BEGAN PRACTICING:** _____
Date City, State

5. **DENTAL LICENSE INFORMATION:**

State	License number	Expiration Date	Status	% of Income

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: _____

II. Dental Training and History (continued)

11. **HAS ANY CLAIM OR SUIT FOR ALLEGED SEXUAL MISCONDUCT EVER BEEN BROUGHT AGAINST YOU?**

NO YES - Explain: _____

12. **HAVE MEDICARE OR MEDICAID AUTHORITIES EVER BROUGHT CHARGES AGAINST YOU?**

NO YES - Explain: _____

III. INSURANCE HISTORY

(PLEASE LIST CARRIER(S) FOR MOST RECENT 5 YEARS; INCLUDING RESIDENCY & FELLOWSHIP)

1. CARRIER INFORMATION:

	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					

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: _____

5. **IF YOU ARE CURRENTLY INSURED BY A CLAIMS-MADE POLICY:**

A. Are you obtaining Extended Reporting ("tail") coverage from your current insurance company?
 NO YES

B. Is Prior Acts coverage being requested?
 NO YES - Indicate Prior Acts effective date*: _____

*If yes, attach a copy of your most recent policy declarations page.

C. Has your practice changed significantly in the last five years?
 NO YES - Explain: _____

VI. CLAIMS HISTORY

Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?

No Yes - Complete the following. If you need more space, use Comments sheet or attach additional sheet.

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence

Allegations:

¹ Claim closed Amount paid on your behalf
\$ _____

¹ Claim open Amount reserved on your behalf
\$ _____

Any additional claims or suits for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?

No Yes - Complete the following. If you need more space, use Comments sheet or attach additional sheet.

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence

Allegations:

¹ Claim closed Amount paid on your behalf
\$ _____

¹ Claim open Amount reserved on your behalf
\$ _____

AUTHORIZATION

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.

Signature of Applicant

Date

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, authorize the release and exchange of information involving either underwriting or claims matters between present or prior insurance carrier, hospital 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

**Medical Security Insurance Company
700 Spring Forest Rd
Raleigh, NC 27609**

PRIOR ACTS COVERAGE CERTIFICATION

(New Business)

Medical Mutual Insurance Company of North Carolina

Medical Security Insurance Company

(hereinafter referred to as the "Company")

(Please TYPE or PRINT in black ink.)

NAME OF APPLICANT: _____

I request Prior Acts Coverage retroactive to: _____
(Retroactive Date)

I hereby certify that I have no knowledge of any professional liability claims which have been asserted against me or any of my affiliates or subsidiaries to which the insurance applied for will cover, or of any occurrence, incident or circumstance likely to result in such a claim on or after the requested initial effective date of the Prior Acts Coverage, except as indicated below.

Please give a brief description of each such claim, occurrence, incident or circumstance. *Notice of any such claim, occurrence, incident or circumstance should be given to your current carrier if such notice has not already been provided.*

I certify that the above is true, complete and correct to the best of my knowledge, information and belief. I understand that my misrepresentation of the facts or failure to provide a true and accurate response to the above questions may result in the denial of claims under any policy or policies issued.

Signed: _____ Date: _____
(Applicant)



Medical Security

**LOSS-FREE ACKNOWLEDGEMENT FORM
(NEW BUSINESS)**

To the best of my knowledge, I have had no professional liability losses of over \$5000.00 paid on my behalf since _____ I understand this statement may entitle me to receive a premium discount on my professional liability policy issued by Medical Security Insurance Company.

Misrepresentation of my loss experience as described above will entitle Medical Security Insurance Company to collect any premium credit previously granted under their Loss-Free Credit Program and may make me ineligible for continued coverage with Medical Security Insurance Company.

Signature of Applicant

Date

MEDICAL SECURITY INSURANCE COMPANY
Sedation Supplemental Questionnaire

Dentist Name: _____

Practice Name: _____

Address: _____

Telephone Number: _____ Email: _____

1. 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.

2. If coverage is being requested for sedation requiring a special permit by the NC State Board of Dental Examiners, the following documents are required and must be attached in order for further consideration:
- A copy of the completed *Application for General Anesthesia or Sedation Permit*
 - A copy of the permit, temporary or permanent, issued by the NC State Board of Dental Examiners.

IMPORTANT: This Sedation Questionnaire must be signed by the insured.

The above statements are an accurate and honest representation of my current practice.

(Signature)

(Date of Signature)