

**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:
- Endodontics Oral Pathology Oral Surgery
 Orthodontics Pediatric Dentistry Periodontics
 Prosthodontics Other (describe) _____
4. **DO YOU PRACTICE IN THE DENTAL FACULTY PRACTICE PLAN?** NO YES
5. **INDICATE WHICH BEST DESCRIBES YOUR PRACTICE WITHIN THE SCHOOL OF DENTISTRY:**
- Dentistry on patients who have been treated with local anesthesia and inhalation sedation (Nitrous Oxide)
- Dentistry described above, and dentistry on patients who have been treated by intravenous or intramuscular sedation. If checked, do you hold a current permit from the State Board of Dental Examiners to administer IV or IM sedation?
 NO YES
- Dentistry on patients who have been treated with general anesthesia. If checked, where are the procedures under general anesthesia performed: Office only Hospital only Both
- Do you perform Dentistry on patients who have been medicated with oral sedating agents to produce Sleep Dentistry?
 NO YES If yes, indicate drugs used: _____

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

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