TEXAS MEDICAL INSURANCE COMPANY
P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax:512-425-5998 • sales@tmic.biz

INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE — DENTIST

PLEASE TYPE OR PRINT IN BLACK INK.
ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER ______________________________
(For TMIC Use Only)

I. GENERAL INFORMATION

A. ____ DDS❑ DMD❑ BDS ❑

First Name | Middle Name | Last Name

____

Home Address | City | State | Zip Code

________________ ________________ ________________

Date of Birth | Dental License /Status | Social Security Number

________________ ________________ ________________

Office phone: Area Code Number | Home phone: Area Code Number | Fax: Area Code Number

________________ ________________ ________________

Pager: Area Code Number | Cell Phone: Area Code Number | Email address

B. Please list all **office locations** where you currently practice or intend to practice. **List principal location first.**

1. ____

Number | Street | Suite | City | State | Zip | County

2. ____

Number | Street | Suite | City | State | Zip | County

C. Preferred Mailing Address: Home ❑ Principal Office ❑ P.O. Box/State/Zip Code ❑ ________________________

D. Other counties where you practice and percentage ________________________

E. Is any of your practice outside of Texas? No ❑ Yes ❑ ________________________
If yes, where?

F. To which local dental societies or associations do you belong? ________________________

Rev 10-17

II. DENTAL LIABILITY INSURANCE COVERAGE

A. Requested coverage effective date 12:01 a.m. ________________/________________/________________
Month Day Year

In no event shall the effective date of the policy, if issued, be earlier than the date TMIC receives this application.

B. Professional Liability Coverage Please check the limits of liability desired (only one).

Occurrence (Limits indicated are Each Claim and All Claims)

❑ $200,000/$600,000 ❑ $300,000/$900,000 ❑ $500,000/$1,500,000

Claims-made (Limits indicated are Each Claim and All Claims)

❑ $200,000/$600,000 ❑ $300,000/$900,000 ❑ $500,000/$1,500,000 ❑ $1,000,000/$3,000,000

C. Insurance History for Previous Three Years

	Current year	First prior year	Second prior year
1. Insurance Company:			
Coverage Form:	❑ Claims-made ❑ Occurrence	❑ Claims-made ❑ Occurrence	❑ Claims-made ❑ Occurrence
Policy Period:			
Limits of Liability Per Claim/All Claims:			

Please note: If your current insurance is written on a Claims-made form, it is necessary to purchase a Reporting Endorsement (tail coverage) from your present insurer or Prior Acts (nose coverage) from TMIC to reduce the chances of having a gap in coverage. Any known incident or circumstance that might reasonably be expected to lead to a claim being made against you must be reported to your prior carrier.

2. Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer for all your previous exposures? Yes ❑ No ❑

If no, are you requesting Prior Acts (nose coverage) from TMIC? Yes ❑ No ❑

III. PRIOR ACTS COVERAGE

If you are requesting Claims-made coverage with Prior Acts, please complete this page.

NOTE: The following questions apply to your **past** Claims-made coverage and need to be answered for the entire time period following your retroactive date.

A. Has any portion of your practice been performed outside the state of Texas? Yes ❑ No ❑

If yes, please list below the states, dates and the percentage of practice for each year.

____

____

B. Has your Claims-made policy ever included coverage for any other individual or for an entity other than a solo professional association, professional corporation or limited liability corporation (LLC)? Yes ❑ No ❑

If yes, please provide details on page 11 of the application and attach any endorsements providing coverage for such other individual (including locum tenens) or entity.

C. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered) which you have reason to believe may lead to a claim or suit against you? Yes ❑ No ❑

D. Have you reported any incidents (which have not yet resulted in a claim or suit) to another insurance carrier? Yes ❑ No ❑

E. Have you received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, complaint, summons, citation or other legal process or notification? Yes ❑ No ❑

If you answered yes to C, D, or E above, you must provide details below. Report all incidents identified under C or E to your current insurance carrier. Doing so does not necessarily eliminate the need for the Reporting Endorsement (tail coverage).

Patient Name	Date of Incident	Date incident report sent to insurance carrier (provide copies)

IV. UNDERWRITING AND RATING INFORMATION

A. Dental Practice History

1. Education

	SCHOOL/HOSPITAL	CITY/STATE	FROM/TO	DEGREE/SPECIALTY
Dental/Medical School				
Residency				
Fellowship				
Additional Training *				

* Can include military, GPR, unversity/clinical

2. a. Did you complete a residency training program? Yes ❑ No ❑
   b. Are you entering practice for the first time immediately following residency training, military service or an academic position? Yes ❑ No ❑

3. a. Are you Board Certified? Yes ❑ No ❑ ____________________
   Name of Board Date(s) Certified

   b. If not certified, are you admissible to a board examination? Yes ❑ No ❑ ____________________
   Name of Board Date(s) Certified

   c. Have you ever failed to pass a board examination? Yes ❑ No ❑ ____________________
   Name of Board Which portion?/Date(s)

4. Are you certified in: ACLS ❑ ATLS ❑ BLS ❑ CPR ❑ PALS ❑

5. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF DENTAL SCHOOL, WITH THE EXCEPTION OF YOUR RESIDENCY OR FELLOWSHIP TRAINING. INCLUDE YOUR SPECIALTY AT THAT TIME.

____________________ From_____/_____ To_____/_____
Specialty City State Country Month Year Month Year

____________________ From_____/_____ To_____/_____
Specialty City State Country Month Year Month Year

____________________ From_____/_____ To_____/_____
Specialty City State Country Month Year Month Year

IV. UNDERWRITING AND RATING INFORMATION

B. Dental Practice Structure/Operations

1. **Practice type:**

❑ Individual/Solo unincorporated

❑ Solo entity, professional association, professional corporation, or limited liability corporation
(Solo entity coverage is automatically provided under individual policy.)

❑ Employee of ____

❑ Locum Tenens

❑ Other ____

Exact name and address of professional entity, practice name, employer, or DBA, etc.

____

2. Do you **Employ** ❑ **Supervise** ❑ **Contract with** ❑
A. licensed dentists (includes Residents or Fellows)? Yes ❑ No ❑

Do you **Employ** ❑ **Supervise** ❑ **Contract with** ❑
B. individuals who administer anesthesia? Yes ❑ No ❑
If yes to 2A or 2B, list below.

Name	Specialty	Insured By	Limits of Liability
Name	Specialty	Insured By	Limits of Liability

3. Do you own a laboratory? Yes ❑ No ❑
If yes, please provide details on page 11 of the application.

4. Do you own and/or perform procedures in a mobile dental practice? Yes ❑ No ❑
If yes, please provide details on page 11 of the application.

5. Indicate the number of personnel in each category.

	Number of employees	Number of independent contractors	Insured by	Limits of Liability
Dental assistants				
Licensed Registered Hygienists				
CRNAs				
Registered Nurses				
Other				

6. Average number of patients seen per week: _________________

7. Average number of practice hours per week involved in both direct patient care and related administrative activities: ___________________

IV. UNDERWRITING AND RATING INFORMATION

C. Dental Practice Description

1. What is your dental specialty? ______________________________

2. Indicate what percentage of time is devoted to the following specialties:

General Dentistry	____________%
Endodontics	____________%
Pedodontics	____________%
Periodontics	____________%
Prosthodontics	____________%
Orthodontics	____________%
Oral Surgery	____________%
Oral Pathology	____________%
Other (please describe on page 11)	____________%
TOTAL	**100%**

3. Please check any of the following procedures you have performed in the past, are currently performing or will be performing.

Orthodontic full-mouth banding ❑
- Malocclusion Class1 ❑
- Malocclusion Class 2 and 3 ❑
- Additional training completed? Residency ❑ CE ❑

Invisalign ❑
- Additional training completed? CE ❑

Implants ❑
- Abutment only ❑
- Surgical placement ❑
- Mandibular multi-quadrant-Ramus frame ❑
- Additional training completed? Residency ❑ CE ❑

Sleep apnea therapy ❑
- Do you treat only after physician referral? Yes ❑ No ❑

Third molar extractions ❑
- Fully erupted ❑
- Partial bony ❑
- Fully impacted ❑
- Additional training completed? Residency ❑ CE ❑

TMJ surgery Yes ❑ No ❑

Sargenti root canal method using N2 or similar paste Yes ❑ No ❑

Elective facial cosmetic surgery/ procedures Yes ❑ No ❑

4. Do you perform reconstructive surgical cosmetic procedures? Yes ❑ No ❑
   Please explain on page 11.

5. Have you discontinued any procedures? Yes ❑ No ❑

   Which procedures: *When discontinued:*

   ____

   ____

6. How often are patients' health histories updated? Annually ❑ Biannually ❑ Every patient visit ❑

7. What percentage of practice is devoted to spa services (including but not limited to Botox/collagen/skin peels)? ________________%

   Ifapplicable,pleaselisttheservicesprovided:______________________________

8. Do you offer obesity/weight control treatment? Yes ❑ No ❑

9. Do you obtain informed consent for all procedures performed? Yes ❑ No ❑

IV. UNDERWRITING AND RATING INFORMATION

C. Dental Practice Description (continued) — Anesthesia/Sedation

10. Is your practice limited to local anesthetic, chloral hydrate or nitrous oxide only? Yes ❑ No ❑
    If yes, please skip to question 21

11. Do you provide anesthesia/sedation in your practice? Yes ❑ No ❑

12. What type of anesthesia/sedation do you provide? (Please check all that apply.)

    ❑ Oral sedation — single dose
    ❑ Oral sedation — multiple dose
    ❑ Intramuscular sedation
    ❑ Intravenous sedation
    ❑ General anesthesia

13. Do you perform procedures on patients who are under anesthesia or sedation which is being administered by other dentists, physicians, or CRNAs? Yes ❑ No ❑

    If yes, how often in the past 12 months? ______________________________

    Please provide details on page 11 of the application.

14. Do you prescribe oral sedation agents (Halcion, Triazolpan, Ativan, Valium, or similar) for use prior to and/or during the patient's scheduled appointment? Yes ❑ No ❑

    a. If yes, do you prescribe to: Children ❑ Adults ❑

    b. If yes, do you prescribe (check all that apply):
    Single dose on day of appointment ❑
    Multiple doses:
    Prior to scheduled appointment ❑
    Prior to and during scheduled appointment ❑
    During the appointment ❑

15. Please describe your anesthesia/sedation training ______________________________

____

16. Please indicate the monitoring equipment used for anesthesia/sedation procedures ______________________________

____

17. What resuscitative equipment/medications do you have available in the office to support any adverse reaction or medical emergency? ______________________________

____

18. Do you obtain written informed consent for each and all anesthesia/sedation procedures? Yes ❑ No ❑
    Please attach copies of your informed consent.

19. Describe what pre-operative instructions are given to the patient ______________________________

____

20. Describe your post-operative instructions and procedures for following up with patients who have received anesthesia/sedation ______________________________

____

IV. UNDERWRITING AND RATING INFORMATION

C. Dental Practice Description (continued)

21. Do you dispense or prescribe medications or use dental devices which have not been approved by the FDA in the treatment or care of human beings? Yes ❑ No ❑

22. Do you and your staff wear masks and surgical gloves when treating patients? Yes ❑ No ❑

23. Do you provide eye protection to your patients? Yes ❑ No ❑

24. Do you autoclave/sterilize equipment for each patient? Yes ❑ No ❑

25. Do you refer patients to specialists and/or work with a team of specialists? Yes ❑ No ❑

26. Do you perform an oral cancer screening of the entire mouth at each routine dental examination? Yes ❑ No ❑

27. Do you advertise? Yes ❑ No ❑
    If yes, please send samples of your Yellow Page display ads and other media advertisements.
    If you use radio or television, please provide details on page 11.

28. Are you an employee or independent contractor for any federal, state, local, or governmental agency? Yes ❑ No ❑
    If yes, please give details including whether professional liability insurance is provided for you on page 11 of the application.

29. Do you perform any volunteer work related to your profession? Yes ❑ No ❑
    If yes, please give details including whether professional liability insurance is provided for you on page 11 of the application.

30. Do you treat federal prison inmates? Yes ❑ No ❑

31. Have you ever been treated for alcoholism or substance abuse? Yes ❑ No ❑
    If yes, provide details and a recent statement of insurability from your treating physician.

32. Have you now or ever had any chronic illness, mental illness or physical impairment? Yes ❑ No ❑
    If yes, provide details and a recent statement of insurability from your treating physician.

33. Do you treat nursing home patients? Yes ❑ No ❑
    If yes, percentage of practice ________________%

34. Do you work for a Management Service Organization? Yes ❑ No ❑

C. Dental Practice Description (continued)

If yes to any of the following questions, please provide details on page 11 of the application.

35. Are you a proprietor, superintendent, executive officer or administrative officer of any business enterprise? Yes ❑ No ❑

36. Do you perform work covered by another professional liability carrier? Yes ❑ No ❑

37. Is laser equipment utilized in your practice? Yes ❑ No ❑

38. Do you provide same day dentures?

39. Has your dental license or permit to prescribe drugs ever been denied, restricted, revoked, suspended or cancelled? Yes ❑ No ❑

40. Is either your dental license or DEA license under pending investigation? Yes ❑ No ❑

41. Have you ever voluntarily surrendered your dental license or DEA license during or following an investigation? Yes ❑ No ❑

42. Has your membership in any professional society or association ever been denied, cancelled, revoked or censured? Yes ❑ No ❑

43. Have you ever been indicted, charged or convicted of a crime other than a minor traffic violation? Yes ❑ No ❑

44. Have any fee complaints or professional relations complaints ever been made against you with your dental association or licensing authority (including Medicare/Medicaid complaints)? Yes ❑ No ❑

45. Have you ever been the subject of disciplinary proceedings, including a dental board action, or been reprimanded by an administrative agency, professional association or peer review committee? Yes ❑ No ❑

46. Has your professional liability insurance **ever** been denied, cancelled, or non-renewed or do you have knowledge that your present insurer plans to cancel or non-renew your coverage? Yes ❑ No ❑

D. Claim information

1. How many professional liability claims have **ever** been brought against you? ____________

   This includes notice of intent to sue, written demand from a patient or lawsuit.
   Complete the information for all claims/suits on pages 12.

V. AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any material misrepresentation or material concealment will void coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding.

All potential claims or lawsuits have been disclosed herein and have been reported to the applicable, prior professional liability insurance carrier. **I understand any policy issued by TMIC will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMIC any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: any county or state professional society, association or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Dental Professional Liability Coverage. I further authorize TMIC and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Regulations, TMIC is a "business associate" of yours. We must use and/or disclose Protected Health Information ("individually identifiable health information that is maintained in any form or medium") in performance of services under this application, and we agree to abide by the obligations set forth in the HIPAA Privacy Regulations. We agree to use and/or disclose the Protected Health Information only as permitted or required. We may use and/or disclose Protected Health Information in our possession for proper management, administration, and/or to fulfill any present or future legal responsibilities proviced that the disclosures are required by law; or that such uses are permitted under state and federal confidentiality laws; or that we have received assurances of the confidential handling of such Protected Health Information under HIPAA Privacy Regulations. We will require all subcontractors and agents — that perform the services we are obligated to perform under this application — to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to you and to us for any Protected Health Information that they received, use, or have access to. Should this application be declined or withdrawn, the protections of this statement will remain in force and we shall make no further use and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law.

By submission of this application, or by acceptance of insurance coverage from TMIC, I hereby release TMIC and its representatives from liability for any acts or omissions in connection with any communications, investigations, or underwriting decisions.

Applicant's Signature ______________________ Date Signed ______________________

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

Coverage will not be considered until this application is completed, signed and dated.
Failure to provide complete information/attachments as requested will cause delay.

VI. ADDITIONAL INFORMATION (Please use this area if additional space is needed for answers to any questions.)

PAGE NUMBER	QUESTION NUMBER	ANSWER AND/OR DETAILS

VII. CLAIM/SUIT INFORMATION ADDENDUM

If additional space is required, please photocopy this form as needed. PLEASE TYPE OR PRINT IN BLACK INK.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

1. CLAIM/SUIT INFORMATION

Patient'sname:______________________________Age:_________Sex:________________Dateofincident:_____________________

Insurancecompanydefendingyourclaim:____

Location: City ______________________________ State ________

ALLEGATIONS and narrative description of the dental facts and your involvement. Please attach a second sheet of paper if additional space is required:

____

____

____

Co-defendants:____

Claim is pending: Yes ❑ No ❑

Lawsuit filed: Yes ❑ No ❑ If Yes: Month ______________ Year _________________

Court Trial: Yes ❑ No ❑ Jury verdict: Yes ❑ No ❑

Settled without indemnity payment on your behalf? Yes ❑ No ❑

Settlement out of court: Yes ❑ No ❑ If Yes: Month ______________ Year _________________

Total amount paid to claimant on **your** behalf: $ ____
Total amount paid to claimant for **all** defendants: $ ____

2. CLAIM/SUIT INFORMATION

Patient'sname:______________________________Age:_________Sex:________________Dateofincident:_____________________

Insurancecompanydefendingyourclaim:____

Location: City ______________________________ State ________

ALLEGATIONS and narrative description of the dental facts and your involvement. Please attach a second sheet of paper if additional space is required:

____

____

____

Co-defendants:____

Claim is pending: Yes ❑ No ❑

Lawsuit filed: Yes ❑ No ❑ If Yes: Month ______________ Year _________________

Court Trial: Yes ❑ No ❑ Jury verdict: Yes ❑ No ❑

Settled without indemnity payment on your behalf? Yes ❑ No ❑

Settlement out of court: Yes ❑ No ❑ If Yes: Month ______________ Year _________________

Total amount paid to claimant on **your** behalf: $ ____
Total amount paid to claimant for **all** defendants: $ ____