OMS NATIONAL INSURANCE COMPANY, RRG
GRADUATING RESIDENT – FIRST YEAR
PROFESSIONAL LIABILITY COVERAGE APPLICATION

For Oral and Maxillofacial Surgeons

In order to expedite the application process, please be sure to answer all questions completely. Please be sure to include all additional documentation as requested in the application, sign and date the application.

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GRADUATING RESIDENT – FIRST YEAR
PROFESSIONAL LIABILITY APPLICATION

This application is for professional liability coverage for a graduating resident beginning his or her first year of practice as an oral and maxillofacial surgeon. A follow up application will be required at the first year renewal.

- Complete all five pages of this application
- Answers must be typed or printed in ink
- Please answer all questions completely
- You must sign and date the application. Signature stamps or signature of office personnel are not acceptable

Notice: Any policy issued as a result of this application is issued by a risk retention group. A risk retention group is not subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty fund protection is not available to a risk retention group.

General Information

Date you would like coverage to begin: ______________________________

1. Name: ______________________________
2. Mailing Address: ______________________________

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   E-mail Address ______________________________

   OMSNIC will only use your e-mail for OMSNIC communications
3. Home Phone Number: ______________ Home Fax Number: ______________
4. Social Security Number ______________ 5. Date of Birth: ______________
6. Primary Practice Location: ______________________________

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   County: ______________ Percentage of Time: ______________

   Office Phone Number: ______________ Office Fax Number: ______________
7. Additional office location**:** ______________________________

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   County: ______________ Percentage of Time: ______________

   How long at this practice location? From: ______________ To: ______________

   (For additional office locations, please indicate on a separate sheet of paper.)
8. How is the practice organized? (Mark One)

   ☐ Self-Employed Solo Practice ☐ Group Professional Corporation*

   ☐ Individual Professional Corporation* ☐ Employed by Another Individual or Entity*

   ☐ Partnership* ☐ Independent Contractor*

   *Please provide name of employer, Corporation name, or Partner's names:

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Coverage Information

Limits of Coverage

NOTE: All Limits of Coverage are not available in all states

Indiana – Limits of $250,000 per patient/$750,000 total limit

Louisiana – Limits of $100,000 per patient/$300,000 total limit

9. Please mark the Limits of Coverage you desire:

☐ $1,000,000 per patient/$3,000,000 total limit
☐ $1,300,000 per patient/$3,900,000 total limit (New York only)
☐ $2,000,000 per patient/$6,000,000 total limit
☐ $3,000,000 per patient/$6,000,000 total limit
☐ $5,000,000 per patient/$6,000,000 total limit

10. Are you requesting coverage for any of the following procedures:

☐ Blepharoplasty ☐ Rhytidectomy ☐ Otoplasty ☐ Hair Transplants

*Coverage is automatically afforded for the performance of rhinoplasty only when performed in conjunction with a maxillary reconstructive surgical procedure.

*If you are requesting coverage for the performance of **blepharoplasty**, **rhytidectomy**, **otoplasty**, **hair transplant** for any reason or **rhinoplasty not** performed in conjunction with a maxillary reconstructive surgical procedure at least two of the following items must be provided.

1. Credentials from a local hospital listing privileges for these procedures.
2. Proof of training (i.e., letter from residency director, fellowship director or preceptor that states you have been "trained to competence" in each procedure requiring coverage).
3. Operative Reports for each procedure: **A**. Five (5) cases in which you were the primary surgeon **B**. Ten (10) cases in which you were the assistant surgeon

11. Do you perform laser facial skin treatment? ☐ Yes ☐ No If yes, please provide proof of training.

12. Do you perform any other procedures outside of the head and neck region? If yes, please specify below.

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Education & Licensure Information

13.

	Name of Institution	Degree	From (Month/Year)	To (Month/Year)
Dental School:				
Medical School:				
Internship:				
OMS Residency:				
Other Residency/ Graduate School:				
Other Specialty:				

14.. Please provide the following licensure information:

State	Dental License Number	State	Medical License Number

DEA License Number: ____________________

- Are you or is your office certified for general anesthesia by a state organization? ☐ Yes ☐ No
  If Yes, please provide permit number: ____________________ Date of Issuance: ________________
- Does your state have a specialty certification for oral and maxillofacial surgery? ☐ Yes ☐ No
  If Yes, Specialty license number: ______________________________

Practice Information

15. If you trained in a specialty other than oral and maxillofacial surgery, do you anticipate performing procedures related to that specialty in your practice? ☐ Yes ☐ No
16. Have you read and do you understand your state's Dental Practice Act? ☐ Yes ☐ No
17. Are the services you intend to render within the scope of the practice act you will be practicing under? ☐ Yes ☐ No
18. Are you aware of what is needed to be HIPPA compliant and do you intend to meet those requirements? ☐ Yes ☐ No
19. Are you an AAOMS member or will you be applying for AAOMS membership? ☐ Yes ☐ No
    AAOMS Member Number: ______________________________
20. Will you obtain written and signed informed consent from your patient prior to performing all oral and maxillofacial surgery procedures (including dentalveolar)? ☐ Yes ☐ No
21. Will you obtain a medical history prior to all oral and maxillofacial surgery procedures? ☐ Yes ☐ No
    Please be advised that it may be contrary to state or local law to ask questions pertaining to AIDS/HIV or the use of illegal drugs on your medial history form. (We strongly recommend that you review your medical history form with your attorney.)
22. Please mark the equipment you use for any sedation and anesthesia cases.

Pulse Oximeter	____________________	Capnography	____________________
Blood Pressure Cuff	____________________	EKG	____________________

Please provide additional detailed information for all "Yes" answers to the following questions on a separate sheet of paper.

23. Have you ever been denied a dental/medical license or the right to take the examination by any state, territory or district? ☐ Yes ☐ No
24. Has any government agency, state board or committee ever suspended, revoked or taken any other action (including probation against either your narcotics license or your license to practice dentistry/medicine) or is either license under investigation in any state? ☐ Yes ☐ No
25. Have you ever been convicted of a criminal offense other than misdemeanor motor vehicle violation? ☐ Yes ☐ No
26. Have you ever been a patient or a participant in any alcohol/chemical dependency or mental health rehabilitation program? ☐ Yes ☐ No
27. Have you been sued or had any claims made against you during your residency? ☐ Yes ☐ No
28. If yes, have these claims been reported to the carrier for your Residency Program? ☐ Yes ☐ No
29. Do you have any knowledge of any incident which occurred within the past three years which might give rise to a claim being made against you? ☐ Yes ☐ No
30. If yes, has this claim been reported to the carrier for your Residency Program? ☐ Yes ☐ No

    Please complete an incident/claims form for each claim for any "Yes" answers to Questions 27 – 30. The incident/claims form can be found on page 5.

Incident/Claim/Investigation Form

Please complete a form for each claim/incident/investigation that you have been involved in. Please make photocopies of this form prior to completion if additional copies are needed.

Patient's Name and Age: ______________________________

Insurance Carrier: ______________________________

Date of Incident: ______________________________

Date Suit Filed: ______________________________

Allegations: ______________________________

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Written Informed Consent Used? ☐ Yes ☐ No

Present Status: (Check One)

☐ No claim yet made ☐ Claim made, suit not yet filed

☐ Suit pending ☐ Claim closed*

*If the claim has been closed, please state the date, method of closing and the amount paid (if any):

☐ Suit dismissed
Date ________________

☐ Suit settled - $________________
Date ________________

☐ Judgment - $________________
Date ________________

Description of Incident:

Please provide a detailed narrative. Include the following in your description along with any other information you feel would be pertinent:
(Please attach additional sheets if necessary.)

- ➔ Your relationship to the case (i.e. primary treater)
- ➔ Exam findings and initial diagnosis
- ➔ Treatment involved
- ➔ Result of treatment and the condition of the patient
- ➔ Patient's subsequent course of treatment
- ➔ If settled, please indicate the reason for settlement

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I HEREBY WARRANT AND REPRESENT THAT the above information is complete and true to the best of my knowledge and belief, and understand that, prior to my retroactive date, there is no coverage for any listed claim or incident provided by the OMS National Insurance Company Policy. I understand that this Incident/Claims Form and the answers and statements provided in this Incident/Claims Form are made a part of any policy that is issued.

Signature: ______________________________ Date: ______________________________

PRIVACY NOTICE

OMS National Insurance Company considers all transactions with us private and confidential. The United States Department of Health and Human Services has issued an opinion letter indicating that the obtaining and maintaining of professional liability insurance is part of health care operations and therefore would not require a business associate agreement or any releases for disclosure of Protected Health Information (PHI) under the Heath Insurance Portability and Accountability ACT (HIPAA).

We may use and disclose Protected Health Information in our possession for proper management, administration and/or to fulfill any present of future legal responsibilities provided 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.

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 receive, 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 uses and disclosures of Protected Health Information, except for the proper management and administration of our business or as required by law.

Acknowledgement

I, The undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject of this application has been omitted or withheld. I understand that these answers and statements are material and as such will be relied upon in the determination by OMS National Insurance Company, Risk Retention Group, ("Company") in granting professional liability insurance coverage. I understand the documents provided with this application are made a part of any policy that is issued. Any concealment or misrepresentation of a material fact will render the insurance issued as a result of this application null and void. Further, it is recognized and agreed that as a prerequisite to acceptance of this application, in consideration for issuing professional liability insurance coverage to me, I agree to abide by any recommendation of the Company's Underwriting Committees.

I authorize any state board of examiners or licensors, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein, to release such information to the Company, its Underwriting Committees or its assigns. I authorize the use of a copy of this Acknowledgment in lieu of its original.

1. I understand that the professional liability insurance for which this application is made is claims-made coverage for an individual oral and maxillofacial surgeon. This claims-made policy covers claims arising from the practice of oral and maxillofacial surgery on or after the Retroactive Date shown in the Declarations, and reported to the Company during the policy period. This policy does not provide coverage for any claim first made and reported before the beginning of the policy period or after the end of the policy period.
2. I understand that the execution of this application is not a guarantee of coverage and that the Company may, in its sole and absolute discretion, accept or reject this application for professional liability insurance coverage.
3. I represent that I have received and carefully reviewed all the information contained in the most recent Information Circular including any supplements thereto and that I have not relied upon any representation or other information (whether oral or written) other than as set forth in the Information Circular and this application or answers furnished in writing by the Company.
4. I am aware that the Company is an Illinois Risk Retention Group which is not subject to all of the insurance laws and regulations of states other than Illinois, including those which provide for state insolvency guaranty funds. Further, I understand that to the extent that the Company may be deemed to be offering a security, the Company is relying on an exception from registration under the Securities Act of 1933 and from the state Blue Sky Laws.

This acknowledgement shall be governed and interpreted in accordance with the laws of the State of Illinois.

Kentucky only – Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a 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.

New York only – Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a 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 ($5,000) and the stated value of the claim for each violation.

Rhode Island only – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Signature: ______________________________ Date: ____________________

DID YOU KNOW?

PROGRAM FEATURES

OMSNIC'S WEBSITE IS www.dds4dds.com
You can obtain sample Informed Consent and Medical History Forms from our website. .

HIPAA COMPLIANCE PROGRAM
You can locate HIPAA forms and take the HIPAA on-line training course on our website.

RISK MANAGEMENT
A risk management course is available on-line at dds4dds.com. You will be eligible to receive a 5% premium credit for three years by taking and passing the on-line course. Live, in-person risk management seminars are also available. Check the website for upcoming seminar information. Courses must be completed within 60 days of the policy effective date to apply the credit to the current policy year.

MONITOR
The *Monitor* is OMSNIC's risk management newsletter that addresses current oral and maxillofacial issues, provides insight to litigation and provides staff information to address office issues. You will receive the *Monitor* via email by providing your e-mail address in question 2. Back issues of the *Monitor* are also available on our website.

POLICY FEATURES

CONTRACTUAL LIABILITY
We will not pay or defend against any liability you have assumed under any contract or agreement unless such liability is otherwise covered by our Policy, and:

You would have been liable for damages without regard to the contract or agreement; **OR** You have assumed liability for damages under a contract or agreement with (a) a Health Maintenance Organization; (b) a Preferred Provider Organization; (c) Independent Practice Organization; or (d) a similar managed care or health care provider organization.

If you have entered into a written or oral agreement with another party, it is strongly recommended that you consult with your personal attorney to determine if there are any deficiencies which may subsequently impact your professional liability insurance coverage.

COVERAGE OUTSIDE THE UNITED STATES
The OMSNIC policy provides coverage for oral and maxillofacial surgery procedures performed outside the United States for a maximum of 30 days in a calendar year when the claim is brought in the United States. The insured's primary practice must be located in the United States.

EMPLOYMENT PRACTICES LIABILITY
Defense coverage is afforded to protected organizations for an employment practices proceeding, i.e., investigation, civil action, demand for arbitration or administrative proceeding, by a present or former employee. The maximum limits per policy period are $25,000 for each covered proceeding/$75,000 annual total for all covered proceedings.

GENERAL ANESTHESIA AND IV SEDATION
Coverage is afforded for the administration of general anesthesia and I.V. sedation as follows:

Regardless of the practice location or type of patient, you are covered for the administration of general anesthesia and I.V. sedation provided: (1) it is for a dental or oral and maxillofacial procedure; (2) properly trained personnel and appropriate equipment are utilized; (3) it is permitted in your state under the dental practices acts and/or other applicable state law; and (4) you are certified.

ORAL AND MAXILLOFACIAL SURGERY
Oral and maxillofacial surgery means the specialty of surgery which includes the diagnosis, surgical and adjunctive treatment of diseases and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

ORGANIZATION COVERAGE
A separate policy is issued for all corporations (solo or multi-insured), partnership, and business entities or to those protected surgeons who practice under a D/B/A. There is no charge for this coverage. This policy protects against covered claims for bodily injury arising out of care provided by protected employees in support of oral and maxillofacial surgery care provided by oral and maxillofacial surgeons who are shareholders and who are insured under individual policies issued by us.

PEER REVIEW
The OMSNIC policy affords coverage for your unpaid service on a review board or committee for AAOMS or one of its constituent professional societies that is responsible for evaluating the professional qualifications or performance of other oral surgeons. This also includes coverage for your paid service on a board or committee sponsored by us for the purpose of assisting our business functions.

UTILIZATION REVIEW
OMSNIC will not pay or defend against any liability for your failure or your refusal to authorize any care or payment for such care in providing utilization review for or on behalf of any managed care organization.