



**OMS NATIONAL INSURANCE COMPANY, RRG  
SECOND YEAR NEW-TO-PRACTICE 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.



OMS NATIONAL INSURANCE COMPANY, RRG
SECOND YEAR NEW-TO-PRACTICE
PROFESSIONAL LIABILITY APPLICATION

A CHECKLIST has been provided for your convenience. Please review and attach all pertinent information. Answers must be typed or printed in ink. Please answer all questions completely. Use additional sheets of paper as needed. You must sign and date the application. Signature stamps or signature of office personnel are not acceptable.

General Information

1. Name: \_\_\_\_\_ Policy # \_\_\_\_\_

2. Primary Practice Location: \_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

3. Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

4. Mailing Address: \_\_\_\_\_

(if different from above)

5. Additional office locations:

2) \_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

3) \_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

4) \_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

For additional office locations, please indicate on a separate sheet of paper.

6. When was the last Risk Management seminar you attended?

\*Host/Location: \_\_\_\_\_ Date: \_\_\_\_\_

\*Please attach a certification of completion if a non-OMS NIC seminar was attended.

7. Total number of hours per average week devoted in your practice to:

A. Actual patient care \_\_\_\_\_ E. Hospital rounds \_\_\_\_\_

B. Actual patient record-keeping \_\_\_\_\_ F. Administrative duties for the office \_\_\_\_\_

C. Consulting \_\_\_\_\_ G. OMS residency training \_\_\_\_\_

D. Night telephone calling your surgical patients for that day \_\_\_\_\_

**General Information (Continued)**

8. Are you ABOMS certified?  Yes  No  
 If yes, date of certification or recertification \_\_\_\_\_  
 If not, are you currently in the certification process?  Yes  No

**Practice Information**

9. Current hospital appointments:
- | Name of Hospital | City  | State |
|------------------|-------|-------|
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |

10. What percent of your office procedures are done under the following (total must equal 100%).
- |  |                               |
|--|-------------------------------|
| General Anesthesia/Deep Sedation: _____% | Nitrous Oxide: _____%         |
| IV/IM – Moderate Sedation: _____%        | Local Anesthesia Only: _____% |
| PO/Enteral Minimal Sedation: _____%      |                               |

11. Please mark the equipment you use for any sedation and general anesthesia cases.
- |                           |                   |
|---------------------------|-------------------|
| Pulse Oximeter _____      | Capnography _____ |
| Blood Pressure Cuff _____ | EKG _____         |

12. On a weekly average, how many surgical procedures do you perform?
- In your office: \_\_\_\_\_ In the hospital: \_\_\_\_\_

13. A. Do you have CT Imaging equipment in your oral and maxillofacial surgery practice?  Yes  No  
 B. If yes, do you provide CT Imaging services on patients other than your own?  Yes  No

14. Approximately how many of the following procedures did you perform in the past 12 months? If none, indicate "0".

**Additional information is required if coverage is desired for the following procedures: blepharoplasty, rhytidectomy, otoplasty, hair transplants or rhinoplasty not performed in conjunction with a maxillary reconstructive procedure. Please refer to the Check List on Page 5 at least two of the following three items must be provided.**

- |  |   |
|--|---|
| A. Extractions-teeth _____                                     | I. Facial fractures _____                       |
| B. General anesthesia/deep sedation _____                      | J. Major reconstructive bone grafts _____       |
| C. Conscious sedation _____                                    | K. Nerve exploration /grafting _____            |
| D. Dental implants _____<br>(Number of Implants, not patients) | L. Benign lesions definitively treated _____    |
| E. Sinus elevation grafting _____                              | M. Malignant lesions definitively treated _____ |
| F. Maxillary osteotomy _____                                   | N. Laser skin resurfacing patients _____        |
| Mandibular osteotomy _____                                     | O. Non-facial liposuction _____                 |
| Distraction osteogenesis _____                                 | P. Blepharoplasty _____                         |
| G. Temporomandibular joint-Open joint _____                    | Q. Rhytidectomy _____                           |
| Arthroscopy _____  | R. Otoplasty _____                              |
| Arthrocentesis _____   | S. Hair transplant patients _____               |
| H. Total or partial prosthetic joint replacements _____        | *T. Rhinoplasty _____                           |

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

**Practice Information (Continued)**

15. Do you perform any other procedures outside the head and neck region?  Yes  No  
If yes, please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Please list below the number of support staff in the following categories employed by you, your partnership, corporation, etc.

Nurses	_____	X-Ray Technicians	_____	Secretarial/Clerical	_____
Surgical Assistants	_____	Dental Assistants	_____	Other (Please describe)	_____
Aestheticians	_____	CRNA's	_____		

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

17. Have you ever been denied a dental/medical license or the right to take the examination by any state, territory or district?  Yes  No

18. 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

19. Have you ever been convicted of a criminal offense other than misdemeanor motor vehicle violation?  Yes  No

20. Have you ever been a patient or a participant in any alcohol/chemical dependency or mental health rehabilitation program?  Yes  No

21. Have you experienced or become aware of any illness or physical disability that impairs or could impair your ability to practice oral and maxillofacial surgery?  Yes  No

**If yes, please include documentation from your treating physician stating your condition, prognosis and any limitations on your ability to practice oral and maxillofacial surgery**

22. Has any insurer ever cancelled, declined or modified coverage (i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused to renew any professional liability insurance policy or any similar insurance?  Yes  No

23. Have you ever had your membership in a professional society suspended, revoked or refused?  Yes  No

24. Have you ever had your hospital privileges reduced, restricted or suspended?  Yes  No

25. Within the past 10 years, have you been sued or have any claims been made against you?  
If yes, have these claims been reported to any prior/current carrier?  Yes  No

**Please complete an incident/claims form for each claim (copy attached).**

26. Do you have any knowledge of any incident which might give rise to a claim being made against you?  
If yes, has this claim been reported to any prior/current carrier?  Yes  No

**Please complete an incident/claims form for each claim (copy attached).**

27. Have you ever been involved in a situation involving the death of a patient?  
If yes, has an incident report or claim been reported to any prior/current carrier?  Yes  No

**Please complete an incident/claims form for each claim (copy attached).**

## 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:** \_\_\_\_\_

**Written Informed Consent Used?**     Yes     No

**Present Status: (Check One)**

- |  |   |
|--|---|
| <input type="checkbox"/> No claim yet made | <input type="checkbox"/> Claim made, suit not yet filed |
| <input type="checkbox"/> Suit pending      | <input type="checkbox"/> Claim closed*                  |

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Suit dismissed<br>Date _____ | <input type="checkbox"/> Suit settled - \$ _____<br>Date _____ | <input type="checkbox"/> Judgment - \$ _____<br>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 Health 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 or 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: \_\_\_\_\_

CHECK LIST

**Did You ?**

1. Sign the Application

2. **INCLUDE:**

- A copy of your approved hospital privilege delineation for each hospital at which you currently have privileges
- Cosmetic surgery documentation (if applicable)  
\*If you are requesting coverage for the performance of **blepharoplasty, rhytidectomy, otoplasty, hair transplants** for any reason or **rhinoplasty not** performed in conjunction with a maxillary reconstructive surgical procedure, at least two of the following three items must be provided for each procedure
  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
- A copy of your yellow page, website address and/or copies of any printed advertising you do
- A blank sheet of your office letterhead
- Any additional information pertinent to your application
- If you are an owner, officer, partner, administrator or employee of any other professional, medical or dental organization, please provide the name of the organization, your status with the organization and the city and state of its location

3. **FOR PART-TIME COVERAGE**

- If you are a full-time student, attach a letter from the registrar which verifies enrollment
- If you are a full-time academician, attach documentation from the institution verifying your full-time status and coverage
- If you are disabled, attach medical documentation from your attending physician regarding your disability
- If you are full-time military or government services oral and maxillofacial surgeon, please provide an explanation with respect to your private practice setting on an additional sheet of paper