

GRADUATING RESIDENT - FIRST YEAR
PROFESSIONAL LIABILITY COVERAGE APPLICATION

INSTRUCTIONS

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.

Date you would like coverage to begin: _____

Name: _____ **Home Phone:** _____

Mailing Address: _____ **Home Fax:** _____

_____ **Email Address:** _____

_____ **Date of Birth:** _____

Social Security Number _____ **Do you wish to receive communications by email?** Yes No

	Name of Institution	Degree	From	To
Dental School:	_____	_____	_____	_____
Medical School:	_____	_____	_____	_____
Internship:	_____	_____	_____	_____
OMS Residency:	_____	_____	_____	_____
Grad School:	_____	_____	_____	_____
Fellowship:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

Please provide the following licensure information:

State	Dental License Number	State	Medical License Number
_____	_____	_____	_____
_____	_____	_____	_____

DEA license number: _____ GA/IV Sedation permit _____

Does your state have a specialty certification for oral and maxillofacial surgery? Yes No

If yes, Specialty license number: _____

Notice: If approved for coverage, you will be required to purchase common and preferred stock in the risk retention group. A description of the stock purchase requirement, as well as the risks involved with ownership of the stock including the restrictions on sale of the stock, are included in the Information Circular, provided on the CD. By signing the application for First Year Professional Liability Coverage, you acknowledge having received and reviewed the new business information CD.

Primary

Practice Location: _____ **Office Phone:** _____

_____ **Office Fax:** _____

****If additional practice locations please include all on a separate sheet of paper.**

How is the practice organized? (Mark One)

- | | |
|--|---|
| <input type="checkbox"/> Self-Employed Solo Practice | <input type="checkbox"/> Group Professional Corporation * |
| <input type="checkbox"/> Individual Professional Corporation * | <input type="checkbox"/> Employed by Another Surgeon * |
| <input type="checkbox"/> Partnership * | <input type="checkbox"/> Independent Contractor * |

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

Please mark the Limits of Coverage you desire. All Limits of Coverage are not available in all states.

- | | |
|-------|--|
| _____ | \$1,000,000 per patient/\$3,000,000 total limit |
| _____ | \$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 |
| _____ | Indiana only - \$250,000 per patient/\$750 total limit |
| _____ | Louisiana only - \$100,000 per patient/\$300,000 total limit |

1. Have you read and do you understand your state's Dental Practice Act? Yes No
2. Are the services you intend to render within the scope of the practice act you will be practicing under? Yes No
3. Are you aware of what is needed to be HIPAA compliant and do you intend to meet those requirements? Yes No
4. Are you an AAOMS member or will you be applying for AAOMS membership? Yes No
AAOMS Member Number _____
5. Will you obtain written and signed informed consent from your patients prior to performing **all** oral and maxillofacial surgery procedures (including dentalveolar)? Yes No

6. Will you obtain a medical history prior to all oral and maxillofacial 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 medical history form. (We strongly recommend that you review your medical history form with your attorney.)

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

8. Are you requesting coverage for any of the following procedures; blepharoplasty, rhytidectomy, otoplasty, hair transplantation, or rhinoplasty? Coverage is automatically afforded for the performance of **rhinoplasty** only when performed in conjunction with a maxillary reconstructive surgical procedure. Yes No
*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 transplants** 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.

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

9. Have you ever been denied a dental/medical license or the right to take the examination by any state, territory or district? Yes No
10. 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
11. Have you ever been convicted of a criminal offense other than misdemeanor motor vehicle violation? Yes No
12. Have you ever been a patient or a participant in any alcohol/chemical dependency or mental health rehabilitation program? Yes No
13. Have you been sued or had any claims made against you during your residency? Yes No
14. If yes, have these claims been reported to the carrier for your Residency Program? Yes No
15. Do you have any knowledge of any incident which occurred within the past 3 years which might give rise to a claim being made against you? Yes No
16. 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 13-16. The incident/claims form can be found on Page 5.

HIPAA STATEMENT

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy and Security Regulations, we are a "business associate" of yours. We must use and/or disclose Protected Health Information including Electronic 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 and Security 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 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 under HIPAA Privacy and Security 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 uses and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law.

Signature: _____ Date: _____

INCIDENT/CLAIMS FORM

Patient's Name: _____

Ins. Carrier: _____ **Date of Incident:** _____

Allegations:

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

Suit dismissed Suit settled \$ _____ Judgment \$ _____

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: _____

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 liability insurance. I understand these documents provided with it 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 liability insurance 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 containing any materially false information or conceals, for the purpose or 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 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.

Signature: _____ Date: _____