OMSNIC

DEFENDING THE SPECIALTY

OMS NATIONAL INSURANCE COMPANY, RRG
NEW BUSINESS PROFESSIONAL LIABILITY 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 and sign and date the application.

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Notice: This policy is issued by your risk retention group, which is not subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty fund protection is not available for your risk retention group.

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.

I. GENERAL INFORMATION:

1. Name:_____ Suffix: ☐ DDS ☐ DMD ☐ MD ☐ PhD
2. Date of Birth: _____ 3. Social Security Number: _____
4. Mailing Address: _____

   City: _____ County:_____ State:_____ Zip:_____
5. E-Mail Address:_____ Website Address:_____

Disclaimer: By providing your e-mail address you agree to receive electronic communication regarding your OMSGuard™ policy and other important company information.

II. COVERAGE INFORMATION:

1. Requested Effective Date:_____ 2. Requested Retro Date:_____

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

Indiana – Only available

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

Louisiana – Only available

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

3. Please mark the Limits of Coverage you are requesting (not applicable for Indiana and Louisiana applicants):

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

4. Please list all of your previous professional liability insurers for the past 10 years:

Insurance Company	Coverage Type	Tail Purchased	From (MO/YR)	To (MO/YR)
_____	☐ Claims Made ☐ Occurrence	☐ Yes ☐ No	_____	_____
_____	☐ Claims Made ☐ Occurrence	☐ Yes ☐ No	_____	_____
_____	☐ Claims Made ☐ Occurrence	☐ Yes ☐ No	_____	_____

Please submit a copy of your current professional liability declarations page along with a 10-year loss run for each insurer listed above.

5. Are you now or have you ever practiced without professional liability insurance? ☐ Yes ☐ No
   If yes, please explain:_____
6. Has any insurer ever cancelled your professional liability insurance for any reason including non-payment of premium or non-renewal? ☐ Yes ☐ No
   If yes, please include a copy of the notice of cancelation.
7. Has your professional liability insurance ever been restricted or limited in anyway? ☐ Yes ☐ No
   If yes, please explain:_____

III. EDUCATION & LICENSURE INFORMATION:

1.

	Name of Institution	Degree	From (MO/YR)	To (MO/YR)
Dental School				
Medical School				
Internship				
OMS Residency				

2. Have you participated in a fellowship? If yes, please provide: ☐ Yes ☐ No
   A. Area of training:
   B. Name of director:
   C. Dates of training:
   D. Is the fellowship accredited? ☐ Yes ☐ No

3. Have you trained in a specialty other than oral and maxillofacial surgery? ☐ Yes ☐ No
   A. If yes, please provide the specialty:
   B. Do you anticipate performing procedures related to that specialty in your practice? ☐ Yes ☐ No
   C. Are you board certified in that specialty? ☐ Yes ☐ No

4. Please provide the following active and inactive licensure information:

Dental		Medical	
State	License Number	State	License Number

5. Please provide your DEA license number:

6. Does your state have a specialty certification for oral and maxillofacial surgery? ☐ Yes ☐ No
   If yes, please provide your license number: #

7. 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:

8. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory board? ☐ Yes ☐ No
   If yes, please submit a detailed narrative of events and a copy of all pertinent documentation.

9. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand? ☐ Yes ☐ No
   If yes, please submit a detailed narrative of events and a copy of all pertinent documentation.

10. When was the last OMSNIC Risk Management seminar you attended? Host/Location: Date:

11. Have you renewed your AAOMS Membership in the past 12 months?: ☐ Yes ☐ No AAOMS ID #

12. Are you ABOMS certified? ☐ Yes ☐ No Recertification Date:

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

IV. PRACTICE INFORMATION:

1. Practice Name:
   Practice Location:
   City: County: State: Zip:
   Office Phone: Office Fax: Home Phone:
   % of time spent at location per week ____ How long have you been at this practice location? From: To:
   Please provide all additional locations requiring OMSNIC coverage on Page 6 of the application.

2. Other than your current locations, please list all locations where you have practiced in the last 10 years. Include military service, if applicable.

Name of practice	Address	From (MO/YR)	To (MO/YR)

3. Do you have an active professional liability policy to cover a practice location for which you are not requesting OMSNIC coverage? ☐ Yes ☐ No

If yes, please provide the following information:

Practice Name:_____

Practice Location:_____

City:_____ County:_____ State:_____ Zip:_____

4. Please indicate all practice location types for which you are requesting coverage:

☐ OMS Office ☐ Nursing Home ☐ Mobile Dental Unit ☐ Government Office ☐ Dental Office/Clinic

☐ Surgi-Center ☐ Hospital ☐ Imaging Facility ☐ Dental Laboratory ☐ University

☐ Spa ☐ Correctional Facility ☐ Multi-Specialty Clinic ☐ Other: _____

5. Do you practice itinerant surgery? If yes, please provide a detailed description of your practice activities ☐ Yes ☐ No

6. List any market segment that represents more than 50% of your annual revenues (e.g. Private Insurance, Medicare, Medicaid):

_____

7. Total number of hours per average week devoted in your practice. If none, enter "0."

Actual Patient Care _____ Actual Patient Record-Keeping _____ Consulting _____

Hospital Rounds _____ Administrative Duties for the Office _____ OMS Residency Training _____

Night Follow-Up Calls for your Surgical Patients for that day _____

8. If you practice on average less than 16 hours per week/800 hours per year as stated in question #7 above, are you requesting part time coverage? If yes, please explain why your practice is limited on Page 6 of the application. ☐ Yes ☐ No

9. What percent of your office procedures are done under the following (total must equal 100%)?

Nitrous Oxide:_____% Minimal Sedation_____% Moderate Sedation:_____% General Anesthesia/Deep Sedation:_____%

10. Do you dispense medications to your patients in your practice? ☐ Yes ☐ No

11. Do you obtain written and signed consent from your patients prior to performing all oral and maxillofacial surgery procedures (including dentoalveolar)? ☐ Yes ☐ No

12. Do you obtain medical history for all patients? ☐ Yes ☐ No
Please attach a sample of all informed consent forms and medical history forms used in your practice.

13. Please mark the equipment you use for any sedation and anesthesia cases.
_____Pulse Oximeter _____Blood Pressure Cuff _____Capnography _____EKG

14. On a weekly average, how many surgical procedures do you perform? In your office:_____ In the hospital:_____

15. Do you perform any other procedures outside the head and neck region? ☐ Yes ☐ No

If yes, please specify:_____

_____

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

Additional information is requires 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.

A.	Extractions-teeth	L.	Facial fracture
B.	General anesthesia/deep sedation	M.	Major reconstructive bone grafts
C.	Conscious sedation	N.	Nerve exploration/grafting
D.	Dental implants (Number of Implants, not patients)	O.	Malignant lesions definitively treated
E.	Sinus elevation grafting	P.	Laser skin resurfacing
F.	Orthognathic maxillary osteotomy	Q.	Blepharoplasty
G.	Orthognathic mandibular osteotomy	R.	Rhytidectomy
H.	Distraction osteogenesis	S.	Otoplasty
I.	Open TMJ surgery	T.	Hair transplant
J.	Arthroscopy	U.	Rhinoplasty
K.	Arthrocentesis	V.	Total or partial prosthetic joint replacements

17. Are you performing full body liposuction? ☐ Yes ☐ No

18. Are you requesting coverage for routine minor medical and surgical procedures, defined as "medical, surgical (incising, excising and/or suturing lesions limited to the skin and immediate subcutaneous tissue) and adjunctive treatment of the diseases and defects of the other body regions"? ☐ Yes ☐ No

19. Current hospital appointments:

Name of Hospital	City/State	Name of Hospital	City/State

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

21. Do you provide CT Imaging services on patients other than your own? ☐ Yes ☐ No

22. Are you involved in teaching, training, or supervising any residents, students, or fellows? ☐ Yes ☐ No
If yes, please complete the following:

a. Name of institution: _____
b. Does the institution provide professional liability coverage for this activity? ☐ Yes ☐ No

23. Have you read and do you understand the state dental practice act and regulatory rules for each state in which you practice? ☐ Yes ☐ No

24. Are the services you render within the scope of those dental practice acts and regulatory rules? ☐ Yes ☐ No

25. Are you and your office HIPAA compliant? ☐ Yes ☐ No

V. CLAIMS & EXPERIENCE INFORMATION:

Please explain all yes answers to Questions 1-4 on page 6 of the application.

1. Have you ever been convicted of a criminal offense other than a misdemeanor motor vehicle violation? ☐ Yes ☐ No
2. Have you ever been a patient or a participant in any alcohol/chemical dependency or mental health rehabilitation program? ☐ Yes ☐ No
3. 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
4. Have you ever been investigated for/or charged with fraud, including Medicaid or Medicare? ☐ Yes ☐ No

5. Within the past 10 years, have you been sued or have any claims been made against you? If yes, how many? _____ ☐ Yes ☐ No
   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).

6. Do you have any knowledge of any incident which might give rise to a claim being made against you? ☐ Yes ☐ No
   If yes, has this claim been reported to any prior/current carrier? ☐ Yes ☐ No
   Please complete an incident/claims form for each incident (copy attached).

7. Have you ever been involved in a situation involving the death of a patient? ☐ Yes ☐ No
   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).

VI. ENTITY AFFILIATIONS: (Entity includes any Dental Corporation, Partnership, Group or other Legal Entity)

1. How is your practice organized? (Mark One)

   ☐ Self-Employed Solo Practice ☐ Group Professional Corporation ☐ Individual Professional Corporation

   ☐ Partnership ☐ Independent Contractor ☐ Employed by Another Individual or Entity

2. Please provide the legal name of all entities at which you are providing services:

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. If ownership interest exists in the entity(s) named above, are you requesting a separate entity policy? ☐ Yes ☐ No
   If yes, please complete the Entity Application.

4. List all professional associates in your practice. (If any partner, shareholder, employee or independent contractor is not insured by OMSNIC, please provide the name of his/her professional liability insurer and evidence of insurance.)

Name of Associate	Position/Affiliation with the Practice	Present Insurer

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

   _____ Nurses _____ Surgical Assistants _____ Aestheticians _____ CRNA's

   _____ X-Ray Technicians _____ Dental Assistants _____ Secretarial/Clerical _____ Other (Describe)

   If you employ any Aestheticians, are you requesting OMSNIC coverage for them? ☐ Yes ☐ No
   If yes, please complete the Cosmetic Supplement form.

Please use this page to provide any additional information requested above in the application. Please reference the question for which you are providing additional information. If additional space is needed, please attach a separate page.

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Incident/Claims/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):

☐ No claim yet made ☐ Claim made, suit not yet filed ☐ Suit pending ☐ Claim closed*

*If 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 (e.g. 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

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 From are made a part of any policy that is issued.

Signature: _____ Date: _____

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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 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.

Prior Acts Certification

If you request coverage for "Prior Acts" for your professional liability exposure, you must inform all prior insurance carriers of any incidents or circumstances that might reasonably result in a claim against you. Please provide written documentation which verifies that you have informed all prior insurance carriers of such incidents or circumstances. It is not the intent of the OMS National Insurance Company Policy to cover known patient injuries which occurred prior to the effective date of your OMS National Insurance Company Policy. Your prior insurance carriers are responsible for covering claims arising out of known patient injuries which occurred prior to the effective date of this policy. Please read and sign the following statement.

> I certify that I am not aware of any incidents which I might reasonably expect to result in a claim, except those listed in this application for insurance. I understand that my OMS National Insurance Company Policy will not provide coverage for such incidents of which I am aware regardless of whether I have reported them to my prior insurance carriers.

Signature: _____ Date: _____

Virginia Cap Limit (VA Only)

I understand that if I elect to participate in the Virginia Cap Limit, my liability limits will increase annually as the recoverable amount increases.

Signature: _____ Date: _____

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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.

Alabama only - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas 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.

Colorado only - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia only - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida only - Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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.

Louisiana only - Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Maine only - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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Maryland only - ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

New Jersey only - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico 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 CIVIL FINES AND CRIMINAL PENALTIES.

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.

Ohio only - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma only -WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania only -Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

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.

Virginia only - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington only - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia 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: _____

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Check List
Did You?

1. READ THE PRIVACY NOTICE
2. READ THE OMSNIC INFORMATIONAL CIRCULAR
3. SIGN THE FOLLOWING:
   - ☐ Page 8, for retroactive coverage (if prior acts coverage is requested)
   - ☐ Page 10, for acknowledgement of application
   - ☐ Each Incident/Claim/Investigation Form
4. INCLUDE:
   - ☐ Samples of all your medical history and informed consent forms
   - ☐ 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 provide for each procedure

     1. Credentials from a local hospital listing privileges for these procedures

     2. Proof of training (e.g., 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
   - ☐ Incident/Claim/Investigation forms (if applicable)
   - ☐ A copy of your current professional liability declarations page (if applicable)
5. FOR PART-TIME COVERAGE REQUESTS:
   - ☐ 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 a 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