MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

P.O. Box 1287, Latham, NY 12110
(800) ASK-MLMIC | MLMIC.com
New York City | Long Island | Colonie | Syracuse | Buffalo

Application for Dentists Professional Liability Insurance

www.MLMIC.com

IMPORTANT NOTICE

Coverage is available to qualifying New York State Dentists, on either an occurrence policy form or a claims made policy form. (Please note your choice below).
If you select the claims made policy form, please be aware that NO coverage will be extended for any incidents, occurrences or alleged wrongful acts which took place prior to the Retroactive Date stated in the policy.
Under the claims made policy form coverage is only provided for incidents that occur on or after the Retroactive Date stated in the policy and which are reported to the Company while the policy is in effect or within 60 days following termination of insurance, unless additional reporting period coverage (Optional Extended Reporting Endorsement) is purchased which would provide an unlimited time period to report covered Claims.
During the first several years, claims made premiums are lower than occurrence premiums but then they increase gradually, independent of overall rate level increases, until the claims made risk reaches maturity.

All applications are subject to prior approval. *If your application is approved, coverage can be provided no earlier than the day following our receipt of the signed and completed application.*

Answer ALL questions. An incomplete application cannot be evaluated. If a question is not applicable, state N/A.

Preliminary Questions

Are you newly licensed in New York? ☐ Yes ☐ No
Have you just completed your GPR? ☐ Yes ☐ No
Are you an Oral Surgeon? ☐ Yes ☐ No

General Information

Last Name	First Name	Middle Name	Date of Birth

License Number	NPI Number	E-Mail Address

Principal Office Phone Number	Cell Phone Number	Home Phone Number	Fax Number

Mailing Address:

Address Line 1	Address Line 2

City	State	Zip Code	County

Home Address: Same as Mailing Address: ☐ Yes ☐ No

Address Line 1	Address Line 2

City	State	Zip Code	County

List all professional office locations requiring coverage from us and percentage (%) of patient hours at each. MUST TOTAL 100%.

Street	City	State	Zip Code	County	% of time
Street	City	State	Zip Code	County	% of time
Street	City	State	Zip Code	County	% of time
Street	City	State	Zip Code	County	% of time
Street	City	State	Zip Code	County	% of time

Are any of the above locations a prison/jail, hospital or nursing home? ☐ Yes ☐ No

Applicant Name: ______________________________

General Information *(continued)*

Are you practicing at a location where coverage is already being provided by another carrier? ☐ Yes ☐ No
If yes, please provide a copy of the declarations page of the policy.
(Please note, coverage for this location will be excluded from this policy)

On what date do you wish the insurance to be effective? 12:01 A.M. Standard Time on: ______________
On which basis do you wish your policy issued? ☐ Claims Made ☐ Occurrence
Select limits of liability you wish the policy to provide:
(*Note: Only Limit Available for New Dentist Flat Rate)

- ☐ $100,000 Each Person/$300,000 Total
- ☐ $200,000 Each Person/$600,000 Total
- ☐ $500,000 Each Person/$1,000,000 Total
- ☐ $500,000 Each Person/$1,500,000 Total
- ☐ $1,000,000 Each Person/$1,000,000 Total
- ☐ $1,000,000 Each Person/$3,000,000 Total*
- ☐ $1,300,000 Each Person/$3,900,000 Total
- ☐ $2,000,000 Each Person/$6,000,000 Total

Have you ever had professional liability insurance? ☐ Yes ☐ No
If yes, provide the following information with respect to all past insurance coverage**.**

Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage
Company Name			Policy Number
Coverage Effective Date	Coverage Expiration Date	Limits of Liability	Type of Coverage

The following questions must be completed by all applicants who were covered on a claims made basis by their prior carrier:

If your immediate past insurance coverage was written on a claims made policy form, do you intend on purchasing Optional Extended Reporting Endorsement ("Tail") coverage from your prior carrier? ☐ Yes ☐ No

PLEASE NOTE: If you select claims made coverage with MLMIC, it will only provide protection for incidents which both occur and are reported on or after the effective date of your policy unless you secure Prior Acts "Nose" coverage from the Company.
(See Request for Prior Acts ("Nose") Coverage)

Request for Prior Acts ("Nose") Coverage

This section should only be completed if you meet the following requirements:

- You are presently covered on a claims made basis by a New York State admitted carrier.
- You are not purchasing Optional Extended Reporting Endorsement "Tail" coverage from your prior carrier.
- There is no coverage lapse between the cancellation date of your current claims made policy and the requested effective date of your MLMIC coverage.

For what period of time are you requesting "Nose" coverage? From (MM/DD/YYYY): ______________ To (MM/DD/YYYY): ______________

A copy of the declaration page of the policy (or policies), including all endorsements in effect during the period for which you are requesting "Nose" coverage must accompany your application. If this information is not included, it will delay the processing of your application.

Applicant Name: ______________________________

Education Information

Dental School Attended:

Name ______________________ Degree ______________________

City ________ State ________ Country ________ From ________ To ________ Year Graduated ________

If you are a Foreign Dental School graduate, are you certified by the State Board of Dental Examiners? ☐ Yes ☐ No

What United States dental school did you attend?

Name ______________________ Degree ______________________

City ________ State ________ County ________ From ________ To ________ Year Graduated ________

Other training - including GPR and specialty training

Name of School/Institution ______________________

City ________ State/Country ________

From ________ To ________ Degree ________

Type of Training ______________________

Name of School/Institution ______________________

City ________ State/Country ________

From ________ To ________ Degree ________

Type of Training ______________________

Please enter your NYS License information:

Type of License ________ License Number ________ Date Licensed ________

Do you hold any other professional licenses? (Active or Inactive) ☐ Yes ☐ No

Type of License ________ State ________ License Number ________ Date Licensed ________

Type of License ________ State ________ License Number ________ Date Licensed ________

Type of License ________ State ________ License Number ________ Date Licensed ________

Have you completed a Risk Management Course within the past 2 years? ☐ Yes ☐ No

If yes, please provide course Certificate of Completion.

Applicant Name: ______________________________

Practice Information

Do you hold any hospital staff appointments? ☐ Yes ☐ No

List current hospital staff appointment(s), including any for which you are applying and estimate annual number of patients admitted by you:

Name of Hospital	Estimated Number of Admissions

Would you like certification of insurance sent to above hospital(s)? ☐ Yes ☐ No

Have you ever practiced at any location(s) other than your current office address? ☐ Yes ☐ No

List locations where you have practiced to date:

City	State	Country	From Date	To Date

NYSDA Status: (Enter the District name or Non-Member) ______________________________

What is your ADA number? ______________________________

List all other professional societies (national, state, county, other) of which you are a member:

____

As of the effective date of this insurance, specify the nature of your current practice (please check all that apply):

- ☐ Solo Practitioner
- ☐ Solo Professional Corporation (P.C.)
- ☐ Multi-Dentist Professional Corporation (P.C.)
- ☐ Part of a DSO
- ☐ Independent Contractor
- ☐ Professional Association (P.A.)
- ☐ Partnership

What are the total hours per week for which you require coverage from MLMIC? ☐ 0-20 hours ☐ 21-40 hours ☐ 40+ hours

(Note: New dentists applying for Flat Rate must be full time.) Average patients per day: _______ per week: _______

Are you an employee of a Professional Partnership, Professional Limited Liability Partnership, Professional Service Corporation, Professional Limited Liability Company, or an individual dentist? ☐ Yes ☐ No

If yes, provide name(s) of employers(s):

____

____

____

Are you a partner of a Professional Partnership, Professional Limited Liability Partnership, a shareholder in a Professional Service Corporation or Association, or a member of a Professional Limited Liability Company? ☐ Yes ☐ No

If yes, provide name(s) of entity(s), tax identification number(s), and your relationship:

Name of entity	TID#	Relationship (partner, etc.)

List all other partners, shareholders, members, and all employed dentists for each entity *(Indicate insurance carrier and Limits of Liability for each).*

Name	Insurance Company	Limits of Liability Each Person/Total

Applicant Name: ______________________________

Practice Information *(continued)*

PLEASE NOTE: Professional Corporation, Association or Partnership Coverage Information

The individual dentist policy issued by the Company affords coverage to your professional corporation, association or partnership named as a Qualified Professional Entity on your policy without additional premium charge. The professional corporation, association or partnership is not provided separate Limits of Liability, rather it shares the Limits of Liability with all other persons insured under your policy.

A separate additional set of Limits of Liability, not shared with other insureds, may be available to a professional corporation, association or partnership composed of two or more dentists (not available to a solo corporation) for an additional premium. (Please refer to the Company for information.)

I have considered the options available to me as described above and *I wish to select the following coverage* for my professional corporation, association or partnership.

☐ Shared Limits of Liability at no additional cost to me.

☐ Additional Limits of Liability for an additional premium (Please contact the Company for information.) A separate application is required.

I certify by checking this box that this is the desire of each member of my professional corporation, association or partnership and will be reflected similarly on their applications for insurance. ☐

What is your primary practice specialty? (choose a description from the chart below) ______________________________

Indicate the percentage of your time involved in the areas of practice shown below (percentages must total 100%):

	Specialty Area of Practice		% of time			Specialty Area of Practice		% of time
(1)	General Dentistry	☐ Yes ☐ No	%		(8)	Orthodontics	☐ Yes ☐ No	%
(2)	Anesthesiology*	☐ Yes ☐ No	%		(9)	Pediatric Dentistry	☐ Yes ☐ No	%
(3)	Cosmetic Dentistry	☐ Yes ☐ No	%		(10)	Periodontics	☐ Yes ☐ No	%
(4)	Endodontics	☐ Yes ☐ No	%		(11)	Prosthodontics	☐ Yes ☐ No	%
(5)	Implantology	☐ Yes ☐ No	%		(12)	Public Health	☐ Yes ☐ No	%
(6)	Oral or Maxillofacial Surgery	☐ Yes ☐ No	%		(13)	T.M.D.*	☐ Yes ☐ No	%
(7)	Oral Pathology	☐ Yes ☐ No	%		(14)	Other* (describe)	☐ Yes ☐ No	%

* Please explain procedures performed for anesthesiology, T.M.D. and/or Other:

Practice Specialty Information:

a. Do you plan to change your specialty? ☐ Yes ☐ No

If yes, please explain:

b. Do you wire jaws closed for weight control? ☐ Yes ☐ No

If yes, please explain:

c. Do you do full mouth rehabilitation solely for cosmetic purposes? ☐ Yes ☐ No

If yes, please explain:

Applicant Name: ______________________________

Practice Information *(continued)*

d. Do you perform the following procedures? (please mark all that apply):

- Diagnostic, Preventative and/or Restorative Non-Invasive Procedures (ex. Non-Surgical TMJ treatments - mouth guards and splints, Cosmetic Whitening Veneers, Botox, Collagen or Restylane) ☐ Yes ☐ No
- Simple Extractions - no extraction of full or partial third molar impacted teeth ☐ Yes ☐ No
- Root Canals ☐ Yes ☐ No
  If yes, percent of practice? ☐ Less than 10% ☐ 10 - 50% ☐ Over 50%
- Restorative Implants ☐ Yes ☐ No
  If yes, percent of practice? ☐ Less than 10% ☐ 10 - 50% ☐ Over 50%
- Extractions of partial third molar impacted teeth ☐ Yes ☐ No
  If yes, percent of practice? ☐ Less than 10% ☐ 10 - 50% ☐ Over 50%
- Placing Implants ☐ Yes ☐ No
  If yes, percent of practice? ☐ Less than 10% ☐ 10 - 50% ☐ Over 50%
- Extractions of full third molar impacted teeth ☐ Yes ☐ No
  If yes, percent of practice? ☐ Less than 10% ☐ 10 - 50% ☐ Over 50%
- Bone graft or sinus elevation surgeries ☐ Yes ☐ No
  If yes, percent of practice? ☐ Less than 10% ☐ 10 - 50% ☐ Over 50%

e. Do you assist oral surgeons in surgery? ☐ Yes ☐ No

If yes, please explain:

____

Anesthesia Usage

a. Do you administer General Anesthesia or Deep Sedation to patients? ☐ Yes ☐ No

If yes, a separate application is also required. Coverage may be provided for an additional premium. Please contact the Company for information

b. Do any of your employees administer General Anesthesia or Deep Sedation to patients? ☐ Yes ☐ No

If yes, please provide name(s):

Name: ______________________________

Name: ______________________________

Name: ______________________________

For all names listed above, attach copies of certification/license to provide General Anesthesia, and copy of current declarations page from professional liability carrier listing name, policy number, effective dates and limits of coverage.

(Please note that you will not be covered for your liability arising out of the acts or omissions of an employee(s) who administers General Anesthesia/Deep Sedation to patients, unless that person(s) is properly certified and licensed in NYS to do so, and insured against liability under separate valid and collectible professional liability coverage of at least the same amount as the Limits of Liability of your policy.)

c. Do you or any of your employees perform procedures on patients under General Anesthesia or Deep Sedation? ☐ Yes ☐ No

If yes, please indicate number of procedures performed annually: In hospital ________ In office ________

Applicant Name: ______________________

Practice Information *(continued)*

d. Do you administer Conscious (moderate) Sedation? ☐ Yes ☐ No

e. Do any of your employees administer Conscious (moderate) Sedation? ☐ Yes ☐ No

If yes, please list name(s) of persons administering Conscious (moderate) Sedation:

Name: ______________________

Name: ______________________

Name: ______________________

For all names listed above, please attach copies of current NYS certification to provide Conscious (moderate) Sedation, and copy of current declarations page from professional liability carrier listing name, policy number, effective dates and limits of coverage.

f. If you answered yes to questions d. and/or e. above, please answer the following:

1) Percentage of patients who receive Conscious (moderate) Sedation ______ %

2) Types of Conscious (moderate) Sedation *(Percentages must total 100%)*

a)	Intramuscular	______ %
b)	Intravenous/parenteral	______ %
c)	Nitrous oxide	______ %
d)	Enteral	______ %
e)	Combination of above	______ %

3) As respects to intramuscular and intravenous sedation, please provide estimated number of patients administered to annually:

	Intramuscular Sedation	Intravenous Sedation
a) number of patients in your office		
b) number of patients in a hospital		

Other than yourself, are there any professional employees or independent contractors in your practice? ☐ Yes ☐ No

If yes, indicate the number. If none, enter zero ("0").

Category	No. of Employees	No. of Independent Contractors
a) Oral Maxillofacial Surgeons		
b) Dentists Using General Anesthesia/Deep Sedation		
c) Dentists Using Conscious (moderate) Sedation		
d) Dentists - All Others		
e) Dental Assistants		
f) Nurse Anesthetists		
g) Dental Hygienists		
h) Technicians - X-Ray		
i) Other (describe below)		

Describe Other: ______________________

Applicant Name: ____________________

Underwriting Information

Please note that you will not be covered for your liability as the owner, director, trustee, proprietor, superintendent, or officer of any hospital, sanitarium, dispensary, clinic, nursing home, laboratory, or any other business enterprise. See policy exclusion

Please note that the coverage afforded for the liability of others which you have assumed under a contract agreement is limited. See policy exclusion

☐ I acknowledge I have read and agree to the terms above.

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE DETAILS IN THE SPACE PROVIDED

Have you ever been convicted of a criminal offense other than a motor vehicle violation? ☐ Yes ☐ No
If yes, please describe:

Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or have you ever voluntarily surrendered same? ☐ Yes ☐ No
If yes, please describe:

Have you ever been denied a professional license, certification by a Specialty Board or membership in any professional society or association? ☐ Yes ☐ No
If yes, please describe:

Has any hospital or other health care facility ever restricted, suspended or revoked your privileges, or placed you on probation? ☐ Yes ☐ No
If yes, please describe:

Have you been investigated by any government agency, including a State Board? ☐ Yes ☐ No
If yes, please describe:

Have you ever voluntarily surrendered your hospital or other health care facility privileges, narcotics or professional license to avoid suspension, restriction, probation or revocation? ☐ Yes ☐ No
If yes, please describe:

Has any insurance company ever declined your application, canceled, refused to renew, restricted coverage or offered professional liability insurance to you with a deductible or at higher than regular rates? ☐ Yes ☐ No
If yes, please describe:

Have you ever practiced without insurance? ☐ Yes ☐ No
If yes, please describe:

Applicant Name: ______________________________

Loss Information - Claims/Suits

Do you have any claims/suits that have been reported to any previous insurance carrier(s)? ☐Yes ☐No

If yes, list ALL malpractice claims or suits asserted against you, and attach copy of claims loss history from your carrier(s).

(a) Include any claims/suits that have been closed with or without payment; and

(b) any claims/suits that are currently pending.

Do not include any claims/suits that occurred during an internship, residency or fellowship.

Incident Date	Report Date	Status	If Closed		Insurance Carrier	Claimant Name
			Date Closed	Amount Paid On Your Behalf		
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						

☐ See addendum for additional claims.

Applicant Name: ____________________

Loss Information - Claims/Suits *(continued)*

Incident Date	Report Date	Status	If Closed		Insurance Carrier	Claimant Name
			Date Closed	Amount Paid On Your Behalf		
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						
		☐ Pending ☐ Closed				
Briefly describe allegations & care/treatment:						

Applicant Name: ____________________

Loss Information - Incidents/Events

Are you aware of any incident(s) or event(s) that may or will result in a Claim or Suit against you or your associate(s)? ☐Yes ☐No

This will include situations such as a request for one of your patient records or any unanticipated material complication(s) related to professional services provided by you.

If the incident/event was reported to your prior insurance carrier, list carrier name in the space provided.

Do not include any incident(s)/event(s) that occurred during an internship, residency or fellowship.

Incident Date	Report Date If Carrier Notified	Insurance Carrier	Claimant Name
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			

☐ See addendum for additional incidents.

No Consent Option

By checking yes, I hereby waive my written, unconditional consent to settle any claim and authorize MLMIC to act on my behalf to settle any claim within policy limits without first obtaining my written consent. I understand that I will receive a 5% premium credit by choosing this option. ☐Yes ☐No

New York State Insurance Regulation Declares That:

"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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Release of Information

I hereby authorize MLMIC Insurance Company and it's affiliates to obtain all information from any insurance company, credentialing data source or other party with respect to me, my professional credentials, or my dental practice, which would include any claim, lawsuit or event pertaining to professional acts or omissions that have been asserted against me or my dental practice, partnership, or professional corporation. I expressly release and discharge from liability any party providing or receiving such information. I consent to the use of my information by MLMIC Insurance Company and its affiliates in their business of insurance. I further authorize that a photocopy of this release be accepted with the same authority as the original.

Date ________ Signature of Insured ____________________

Signature of Submitter ____________________

Applicant Name: ______________________________

Loss Information - Incidents/Events *(continued)*

Incident Date	Report Date If Carrier Notified	Insurance Carrier	Claimant Name
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			
Briefly describe incident:			

APPLICATION: DENTIST PART-TIME INSURANCE

Name: ____

A premium discount will be provided to qualified dentists whose total practice to be covered under a MLMIC policy will not exceed twenty (20) hours in any given week.

I. How many hours weekly do you spend in your total dental practice? **(Include all professional activity as a dentist, even if covered by other insurance.)**

Hours By Day of Week

	In Office	Other	Total Hours
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

(a) Of the total hours listed in the grid above, how many are or will be covered by other insurance and not by your individual MLMIC policy? (if none enter 0): _________

Describe all activities covered by other insurance and provide name(s) of other carrier(s):

____

(b) State the maximum number of hours for which you require coverage under an individual MLMIC policy: __________

As a further condition for a reduced premium, I herein consent to an audit of my records to substantiate the limited hours of practice to be covered by MLMIC insurance.

New York State Insurance Regulation Declares That:

"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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

__________ ______________________________

Date Signature of Insured

Release of Information

I hereby authorize MLMIC to obtain full information from any insurance company or from any person with respect to me or my medical practice, including but not limited to, any claim or suit or incident pertaining to professional acts or omissions asserted against me and/or my partnership or professional corporation. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

____

Signature of Submitter