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

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

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? ☐ 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 _____

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

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

What is your ADA number? _____

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:

_____

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 _____

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.

Applicant Name: _____

Practice Information *(continued)*

f. If you answered yes to 8d. and/or 8e., 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		

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:

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 _____