6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

Employed, Subcontracting or Volunteer Dentist Community Clinic Program Application for Professional Liability Insurance Additional Insured Basis

Please type or print. Answer all questions. Please note that this application is for coverage limited to services rendered while employed by, or practicing as a sub-contractor or volunteer of the entity listed in Question 2.

PERSONAL INFORMATION / REQUESTED COVERAGE — ANSWER 1-3

1. PERSONAL INFORMATION ☐ Male ☐ Female

First Name ____ M.I. ____ Last Name ____ Date of Birth ____ Place of Birth ____ Country ____

2. NAME OF MIEC POLICYHOLDER

Name of Clinic ____

Type of association: ☐ W2 Employee ☐ 1099 Independent Contractor ☐ Other (Specify) ____

3. REQUESTED COVERAGE EFFECTIVE DATE

Month ____ Day ____ Year ____

I request that this insurance commence at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year.

NOTE: Approval for coverage and actual effective date are subject to the decision of MIEC's Underwriting Department.

ADDITIONAL COMMENTS

LICENSES / BOARD CERTIFICATION — ANSWER 4-5

4. ACTIVE LICENSES/CERTIFICATES

State ____ License Number ____ Date Licensed ____ Expiration Date ____

State ____ License Number ____ Date Licensed ____ Expiration Date ____

LICENSES / BOARD CERTIFICATION cont'd — ANSWER 4-5

5. **BOARD CERTIFICATION**

Are you Board certified? ☐ Yes ☐ No

Name of Board__________________________ Year Certified______________

Name of Board__________________________ Year Certified______________

If not currently certified, are you Board eligible? ☐ Yes ☐ No

Do you intend to take the Board examination? ☐ Yes ☐ No When?______________

If you are no longer Board eligible, state reason:______________

____

CONTINUING EDUCATION / DENTAL EDUCATION — ANSWER 6-10

6. **DO YOU PARTICIPATE IN AN APPROVED PROGRAM OF CONTINUING EDUCATION?** ☐ Yes ☐ No

Where?______________

7. **DENTAL SCHOOL**

Name of School | City | State | Country

From (mm/yyyy) | To (mm/yyyy) | Degree

8. **ADVANCED SPECIALTY EDUCATION PROGRAM**

Name | City | State | Country

Specialty | From (mm/yyyy) | To (mm/yyyy)

9. **ADDITIONAL TRAINING**

Name | City | State | Country

Type of Training | From | To

10. **DO YOU BELONG TO ANY DENTAL PROFESSIONAL SOCIETIES OR ORGANIZATIONS?** ☐ Yes ☐ No

If so, please list them: ______________

____

____

PRACTICE, SCOPE AND PROCEDURES — ANSWER 11-18

11. How many hours per week do you render professional services as an employed or contract dentist of the entity under which you are applying for professional liability coverage?______________

12. How many patients per week do you see on behalf of the clinic?____________

13. Do you have a separate private practice? ☐ Yes ☐ No

    If yes, do you carry individual professional liability insurance for this private practice? ☐ Yes ☐ No

    Name of carrier______________________________

    Limits of Liability______________________ Expiration Date of Policy______________________

    Does coverage extend to service you render at the clinic? ☐ Yes ☐ No

    If yes, please submit evidence of coverage.

14. Please provide the percentage of your practice at the clinic which fall into the following categories:

    ___________Oral Pathology ___________ Endodontics ___________ Implantology

    ___________Extraction of teeth ___________ Prosthodontics ___________ Periodontics

    ___________Pediatric dentistry ___________ Forensic Dentistry ___________ Filling

    ___________ Cleaning ___________ Sports Dentistry ___________ Gnathology

    ___________Orthodontics ___________ Geriatric Dentistry ___________ Oral or Maxillofacial surgery

    ___________ Temporomandibular joint spec. (TMI) ___________ Other (specify)______________________

    A. For Endodontics:

    Do you use the Sargenti Technique utilizing N2 paste? ☐ Yes ☐ No

    Frequency of use:______________________________

15. Please check and list all anesthetic or analgesic modalities which you use in your practice at the clinic and the percentage of usage.

    ___________ Local anesthetic ___________ Nitrous oxide ___________ Valium

    ___________ Nisentil ___________ Noctec ___________ Inhalation

    ___________ Name other agents used______________________________

16. Do you administer general anesthetics for your clinic patients? ☐ Yes ☐ No

    If yes, please answer the following:

    A. ☐ In your office ☐ Hospital ☐ Other______________________

    Name the hospitals and describe other places you use______________________

    ____

    B. Procedures for which you administer anesthesia______________________

    C. Describe your training in general anesthesia______________________

    ____

    1. Hospitals______________________ Date______________

       Directors of anesthesia training______________________

    2. Other institutions______________________ Date______________

       Directors of anesthesia training______________________

16. Cont'd.

3. Preceptorship (place)________ Date________

   Name of instructors________

4. Other courses________

   Describe:________

D. What anesthetic agents do you generally use?________

E. How long have you been using these or similar agents?________

F. What percentage of your practice is under general anesthetic?________

17. Do you treat clinic patients under a general anesthetic administered by someone else? ☐ Yes ☐ No

If yes, please answer the following.

A. Specify who administers:

☐ MD anesthesiologist ☐ DDS anesthesiologist ☐ MD ☐ DDS ☐ CRNA ☐ Other

If "other," explain and state names of persons who usually administer it with their degrees (if applicable). ________

B. Where do you perform dental services to patients under general anesthesia?

☐ Hospital ☐ Office ☐ Other. Please describe:________

C. How many patients of the clinic receive general anesthesia per week? ________

18. Do you administer intravenous sedation or inhalation analgesic at the clinic? ☐ Yes ☐ No

If yes, answer the following questions.

A. Describe your training in sedation or inhalation analgesia:________

1. Hospitals________ Date________

   Directors of anesthesia training________

2. Other institutions________ Date________

   Directors of anesthesia training________

3. Preceptorship (place)________ Date________

   Names of instructors________

4. Other courses________

   Describe:________

5. Describe specific training in intravenous sedation and/or inhalation analgesia.________

PRACTICE, SCOPE AND PROCEDURES, cont'd.	ANSWER 8-15

18. **Cont'd.**
    6. What agents do you usually use for intravenous sedation or inhalation analgesia?______________________________

INSURANCE HISTORY	ANSWER 19

19. INSURANCE

Has any insurance carrier ever declined, canceled, refused to renew, restricted, or rated up your professional liability insurance? ☐ Yes ☐ No

If yes, give details. ______________________________

GOVERNMENTAL ACTION	ANSWER 17-20

20. GOVERNMENTAL ACTION

Have you ever been investigated as the subject of, charged with or convicted of a misdemeanor or felony in this state or any other state or country?

☐ Yes ☐ No

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21. Have you ever entered a "no contest" plea to a crime, other than a traffic violation? ☐ Yes ☐ No

If you answered "yes" to Question 17 or 18, please furnish full details on your letterhead, including the following information.

A. The nature of the investigation, the charge made or entered against you and the date and jurisdiction in which it was made or entered.

B. The substance of the investigation or allegations made or entered in the charge.

C. The manner in which the investigation or charge was resolved (i.e., dismissal, conviction, etc.).

D. Any additional information concerning the investigation or charge as you may deem appropriate.

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22. Have you ever been investigated by any state or federal regulatory body? ☐ Yes ☐ No

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23. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your dental license?

☐ Yes ☐ No

If you answered "yes," to questions 19 or 20, please furnish full details, included the following information.

A. The reasons for the suspension, restriction, termination, curtailment, revocation, or nonrenewal of your license, and/or the disciplinary action.

B. The substance of both the allegations and findings in any such action, proceeding, hearing, or procedure involving the suspension, restriction, termination, curtailment, revocation, or non-renewal of your license and/or disciplinary action.

C. The date of suspension, restriction, termination, curtailment, revocation, or non-renewal of your license, and/or the disciplinary action; the full name of the licensing agency and its full address.

D. Any additional information concerning such action, proceedings, hearing, or procedure as you may deem appropriate.

HEALTH	ANSWER 24-25

24. HEALTH

Have you ever received treatment or consultation for drug or alcohol abuse? ☐ Yes ☐ No

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25. Are you being treated for any medical condition, disease or illness that affects your ability to practice dentistry? ☐ Yes ☐ No

If you answered "yes" to questions 21 or 22, please furnish full details, which must include:

A. The nature of the condition for which you sought treatment or consultation; the hospital or other institution at which you treated or were consulted and its full address; the hospital or other institution with which you were affiliated at the time and its full address; the name of the individual with whom you treated or consulted; the date(s) of treatment or consultation.

B. The name of the treatment or consultation and the recommended course of continuing treatment or consultation.

C. The manner in which the condition for which you were treated or consulted currently affects your day-to-day activities.

D. Any additional information concerning the treatment or consultation as you may deem appropriate.

CLAIMS HISTORY	ANSWER 26

26. CLAIMS

Have you ever been involved in a malpractice claim, suit or arbitration proceeding, or reported any incidents which resulted in a claim to a former carrier? ☐ Yes ☐ No

If yes, please complete a Claim Information Form for each claim or suit on page 7.

CLAIM INFORMATION FORM

☐ Attachment contains this information ☐ None [Please be sure to check here if no claims]

Name of Patient/Claimant ______ Gender ______ Age ______

1. Condition and diagnosis of patient prior to treatment and/or surgery:

2. Date(s) and type of treatment and/or surgery rendered by you:

3. Condition of patient subsequent to treatment and/or surgery by you:

4. Nature of allegation:

5. Was a suit ever filed against you? ☐ Yes ☐ No

   If yes, was it served? ☐ Yes ☐ No

   When? ______

6. Names of other doctors and hospital, if any, involved:

7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

Name of insurance carrier defending you ______ Name of attorney defending you ______

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to Medical Insurance Exchange of California, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that all statements and answers in this application are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned understands that this application for professional liability coverage, if accepted, will apply only to professional services rendered while acting within the scope of undersigned's duties as an employee of, sub-contractor of or volunteer for the entity shown under Question 2 of the attached application.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature and Title

Print Name

Date

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society.

I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

Signature and Title

Print Name

Date

Facility Name and Address

City

State

Zip

WARRANTY

I understand that the insurance coverage is limited to my practice while working within the scope of my duties as an employed, subcontracting or volunteer dentist of the individual or entity and while at the location(s) listed on page one and shall not apply to any separate private practice, or to services rendered at any other facility. I further understand that the coverage applicable to me is governed by the terms, conditions and exclusions, of the policy or policies issued by MIEC to the individual(s) or entity shown under Question 2 of this application.

Signature and Title	Print Name	Date

You can send in your application by:

1. **Mail-** {Print PRE-PAID Mailing Label]
2. **Fax- (510) 318-6700**
3. **E-mail-** Underwriting@MIEC.com

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 739 OAKLAND, CA

POSTAGE WILL BE PAID BY ADDRESSEE

Medical Insurance Exchange of California
Attn: UNDERWRITING
6250 Claremont Avenue
Oakland, CA 94618-9983

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