OMSNIC

DEFENDING THE SPECIALTY

OMS NATIONAL INSURANCE COMPANY, RRG
NEW BUSINESS ENTITY PROFESSIONAL LIABILITY APPLICATION

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.

OMSNIC
DEFENDING THE SPECIALTY

OMS NATIONAL INSURANCE COMPANY, RRG
NEW BUSINESS ENTITY PROFESSIONAL LIABILITY APPLICATION

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.

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.

ENTITY APPLICATION (Entity includes any Corporation, Partnership, Group or other Legal Entity). THIS FORM IS REQUIRED TO BE COMPLETED FOR A SEPARATE ENTITY POLICY. PLEASE SUBMIT A COPY OF THE ENTITY'S ARTICLES OF INCORPORATION OR ARTICLES OF ORGANIZATION.

I. ENTITY INFORMATION:

1. Legal Name of Entity: _____

2. Mailing Address: _____

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

3. Name of Owner(s)/Partner(s): _____

   _____

4. Name of Practice Administrator: _____

5. Entity Website: _____

6. List any Doing Business As names (DBA's): _____

   _____

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. Has the entity's professional liability coverage ever been declined, cancelled or non-renewed? ☐ Yes ☐ No
   If yes, please submit copy of any notice.

III. OFFICE LOCATIONS:

List all current practice locations in this section. Please assign a Facility Code to each location to identify the type of office location. Please use the space provided on page 3 of the supplement for additional locations.

Facility Codes: 01-OMS Office 02-Hospital 03-Nursing Home 04-Government Office 05-Surgi-Center
06-Dental Office 07-Dental Laboratory 08-Mobile Dental Unit 09-Spa 10-Imaging Facility
11-University 12-Correctional Facility 13-Other_____

1. Facility Code: _____

   Address: _____

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

   Phone Number:_____ Fax Number:_____

2. Facility Code: _____

   Address: _____

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

   Phone Number:_____ Fax Number:_____

3. Facility Code: _____

   Address: _____

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

   Phone Number:_____ Fax Number:_____

IV. ENTITY OPERATIONS:

1. Please provide census information for each Oral & Maxillofacial Surgeon/Dental Specialist affiliated with your entity. Please assign an Affiliation Code for each individual.

   Please submit a certificate of insurance for each Oral & Maxillofacial Surgeon/Dental Specialist affiliate.

   Affiliation Codes: 01 – Owner/Partner/Shareholder 02 – Employee 03 – Independent Contractor

	Name/Affiliation Code	Specialty	Insurance Carrier	Is this their primary location? (Y/N)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

2. Please provide the number of Allied Health Personnel working in your office:

   Dental Assistants:_____ Dental Hygienists:_____ (A)estheticians:_____ RN:_____ LPN:_____ CRNA:_____

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

4. Is the entity planning on establishing more office locations within the next 24 months? ☐ Yes ☐ No
   If yes, please elaborate on page 3 of the application.

5. Has the entity ever filed for bankruptcy? ☐ Yes ☐ No
   If yes, please explain on page 3 of the application.

6. Does the entity contract with any governmental facility such as prisons, VA Hospitals, etc.? ☐ Yes ☐ No
   If yes, please provide a copy of any contracts between the entity and the facility.
7. Does the entity own or operate any other business? ☐ Yes ☐ No
   If yes, please explain a description of the business and the relation to the entity applying for coverage in the space below.
8. Is the entity funded by venture capital? ☐ Yes ☐ No
9. List any market segment that represents more than 50% of your annual revenues (e.g. Private Insurance, Medicare, Medicaid):

   _____

V. CLAIMS & EXPERIENCE INFORMATION:

Please complete the Incident/Claims/Investigation Form for all yes answers.

1. Has a malpractice claim ever been filed against the entity? If yes, how many? _____ ☐ Yes ☐ No
2. Has any affiliate of the entity ever been named in a malpractice claim or suit? ☐ Yes ☐ No
3. Are you aware of any incidents that occurred that might give rise to a malpractice claim or suit? ☐ Yes ☐ No
4. Has the entity ever been involved in a situation involving the death of a patient? ☐ Yes ☐ No

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

OMSNIC
DEFENDING THE SPECIALTY

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: _____

OMSNIC
DEFENDING THE SPECIALTY

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: _____

OMSNIC
DEFENDING THE SPECIALTY

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.

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: _____