LOUISIANA DENTISTS

Application for Professional Liability Insurance

In order to allow adequate time for our underwriting review process, we ask that you please submit your application at least 30 days in advance of your requested effective date. Incomplete submissions or lack of required information will delay the underwriting process. After your application has completed the underwriting process, you will be promptly notified.

Please read the following instructions in order to expedite the review of your application:

1. Save this PDF to your local computer
2. Answer all questions or mark “N/A” where appropriate
3. Save and print your document
4. Sign and date your application
5. Complete the attached Claim Addendum if a claim or suit has been filed against you
6. Submit a loss summary report from your previous carrier(s) – 10 years if applicable
7. Provide a copy of your current professional liability policy or declarations page
8. Provide a copy of your Curriculum Vitae
9. Fax the signed application to 504.841.5205 or scan the signed application to email to your Underwriter

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (6) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

If you have questions, please call the Underwriting Department at 504.831.3756 or 800.452.2120.

Thank you for your interest in LAMMICO. We look forward to serving your dental professional liability insurance needs.

When complete, please remit this application to:

LAMMICO
One Galleria Blvd., Suite 700
Metairie, LA 70001
FAX: 504.841.5205

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LOUISIANA DENTISTS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Under the "**Claims-Made**" policy, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force. Under an "**Occurrence**" policy, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is reported.

Personal Information

			Application # (LAMMICO use only)	
Full Name (Last, First, Middle Initial)		Suffix ☐Jr. ☐Sr. ☐III ☐IV	Gender ☐Male ☐Female	NPI#
Primary Practice Address (include city, state, zip)			Years at this location	
Mailing Address (include city, state, zip)			Other Locations (if any)	
Home Address (include city, state, zip)			Parish Dental Society	
Group Name (if any)	Social Security No.	Date of Birth / Website Address	Email Address	
Office Phone	Fax Number	Home Phone	Cell Phone	

(LAMMICO Use Only)

Retroactive Date _____

Parish Code _____ Tax Code _____

Specialty/Class _____

Discount Code _____ Discount _____ %

Limit/Option _____ Group Code _____

Start of Practice Date _____

Requested Effective Date: _____ / _____ / _____

MM DD YYYY

Professional Liability Limits Desired (Check one box)

Occurrence	Claims-Made	Higher Limits Coverage*
☐	☐	$1,000,000 each medical incident/$3,000,000 aggregate
☐ N/A	☐	$2,000,000 each medical incident/$2,000,000 aggregate
☐ N/A	☐	Higher Limits: Please refer to Company
		Basic Limits Coverage
☐	☐	$100,000 each medical incident/$300,000 aggregate **with** PCF
☐	☐	$100,000 each medical incident/$300,000 aggregate **without** PCF

* Louisiana Patients' Compensation Fund participation is mandatory if you purchase limits greater than $100,000/$300,000

Underwriting and Rating Information

1. Are you a member of the Louisiana Dental Association (LDA)? ☐ Yes ☐ No
2. Do you have a current license to practice dentistry in LA? ☐ Yes ☐ No LA License #.: _____
   (a) State and Federal narcotics license numbers: _____
   (b) Do you have any restrictions? (if *yes*, explain) _____ ☐ Yes ☐ No DEA #: _____
3. List other states where licensed and license numbers: _____

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4.

Undergraduate School, Location	Degree	Year
Dental School, Location	Degree	Year
Served Internship at:	Specialty	Year(s)
Served Residency at:	Specialty	Year(s)
Fellowship or Postgraduate Training, Location	Specialty	Year(s)

5. Date you began, or will begin practicing: _____
(MM/DD/YYYY)

6. Are you certified by an approved specialty board? (If *yes*, which?) _____ ☐ Yes ☐ No

(a) Has there been a change in status? (If *yes*, explain) _____ ☐ Yes ☐ No

7. How many continuing dental education credits did you achieve last year? _____

8. If you are coming to Louisiana from another state or country, why? _____

9. What is your dental specialty? _____

Indicate percentage of time devoted to the following dental and/or surgical activities: (total should equal 100%)

%	%	%	%
___ General Dentistry	___ Orthodontistry	___ Pedodontistry	___ Peridontistry
___ Prosthodontistry	___ Endodontistry	___ Oral & Maxillofacial Pathology	___ Dental Public Health
___ Dental Anesthesiology	___ Oral & Maxillofacial Surgery		

Other:
Specify Type: _____
Additional Specialties _____

10. Dental Procedures (Please indicate whether you perform any of the following):

☐ **Anesthesia**

- ☐ Conscious sedation using types of anesthesia such as local, nitrous or oral sedation (swallowed) in office only
- ☐ Unconscious sedation (which includes I.V. or I.M. sedation and general anesthesia) in dental office sedation is administered by a Dental or Medical Anesthesiologist, CRNA or other
- ☐ Oral and Maxillofacial Surgery performed only in a hospital by surgeon who administers personally or by an employed/contracted Anesthesiologist, any general anesthetic intended to cause unconsciousness
- ☐ Oral and Maxillofacial Surgery performed in a dental office by surgeon who administers personally or by an employed/contracted Anesthesiologist, any general anesthetic intended to cause unconsciousness

☐ **Implants Involving Osseo Integration**

11. Do you administer any sedation/anesthesia in your practice? If yes, please mark all that apply to your practice:

☐ Local Anesthesia ☐ Nitrous Oxide ☐ Multi-Dose Oral Sedation ☐ PO/Enteral- Minimal Sedation
☐ IV/IM- Moderate Sedation ☐ General Anesthesia- Deep Sedation
☐ Sedation/ anesthesia to patients other than your own ☐ Sedation/ anesthesia to special needs patients

12. Please indicate each individual, other than yourself, that administers sedation/anesthesia other than nitrous oxide and local anesthetic in your practice:

☐ CRNA ☐ Dental Anesthesiologist ☐ Medical Anesthesiologist ☐ Other _____

13. How many of the following procedures do you intend to provide on an annual basis?

☐ Surgical Placement of Implants_____ ☐ Extractions of Impacted Teeth_____

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14. Do you provide treatment for Obstructive Sleep Apnea (OSA)? ☐ Yes ☐ No
    If yes, please complete the following:
    (a) Do you obtain referral from the patient's physician before treating? ☐ Yes ☐ No
    (b) Does your treatment include a surgical procedure? ☐ Yes ☐ No
    If yes, please explain in "Remarks."
15. Do you perform any procedures unrelated to the diagnosis and treatment of teeth and the oral cavity? ☐ Yes ☐ No
    If yes, please submit a detailed explanation of the procedure, the quantity performed and the purpose of the procedure in "Remarks."
16. Do you utilize injectable neurotoxins (i.e. Botox) and/or Dermal Fillers (i.e. Artefill, Collagen, Hylaform, Restalyne) in your practice? ☐ Yes ☐ No
17. Do you participate in experimental procedures, devices, drugs, therapy or clinical research in treatment or surgery? If *yes*, please describe in "Remarks." ☐ Yes ☐ No
    Do you follow FDA-approved protocols? If *no*, please describe in "Remarks." ☐ Yes ☐ No
18. Type of practice:
    ☐ Solo ☐ Partnership ☐ Corporation ☐ Employee ☐ Other _____

    (a) Give names of all dental partnerships, professional dental corporations, or other business entities:

    _____

    _____

    _____

    _____

    (b) Name each partner/shareholder who is insured by LAMMICO

    _____

    (c) Name each partner/shareholder who is not insured by LAMMICO

    _____

    (d) **Is a dental corporation, partnership, or other entity to be added as an additional insured on your policy?** ☐ Yes ☐ No
    If *yes*, provide a copy of the Articles of Incorporation or Partnership Agreement for each entity that is to be covered.

    (e) **Do you want separate limits of liability for the entity?** ☐ Yes ☐ No

    (f) If employed, name of employer:_____
19. Do you (or your partnership/association/corporation/joint venture) employ or supervise in a dental office any of the following?
    Certified registered nurse anesthetists (CRNAs) ☐ Yes Indicate# _____ ☐ No
    Anesthesiologist ☐ Yes Indicate# _____ ☐ No
    Other Licensed practitioner- list in "Remarks" ☐ Yes Indicate# _____ ☐ No

    NOTE: If you answered "yes" to any part of question 19, please list all names in the "Remarks" section. If you want to apply for insurance for these medical professionals through LAMMICO, please indicate in the "Remarks" section.

    (a) Are the providers listed above currently covered by LAMMICO? ☐ Yes ☐ No
    If covered elsewhere, please provide certificates of insurance.
    (b) Are the providers listed above independent contractors? ☐ Yes ☐ No
    If *yes*, please list names and provide certificates of insurance: _____
20. Do you market, advertise, or practice dentistry outside Louisiana? ☐ Yes ☐ No
    If *yes*, please explain: _____

    _____

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21. Do you dispense drugs (other than free samples) in your office? ☐ Yes ☐ No
    If *yes*, state your Louisiana State Dispensing number _____ and outline your training and record keeping under "Remarks" section.
22. Has there been any change in your practice or specialty in the past five years? ☐ Yes ☐ No
    If *yes*, please describe: _____
    _____
23. Are you applying for insurance to cover only part-time practice or moonlighting activities? ☐ Yes ☐ No
    (If *yes*, please explain in the "Remarks" section of this application) Number of hours per month: ____

NOTE: If you answer yes to any of the following questions, please give detailed information in the "Remarks" section of this application. (Attach additional sheets if necessary.)

24. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? ☐ Yes ☐ No
25. Has your license to practice dentistry or your narcotics license ever been revoked, voluntarily suspended, subjected to investigation, probation/restrictions or are you aware of any circumstances that might lead to such? ☐ Yes ☐ No
26. Has your membership in any dental association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? ☐ Yes ☐ No
27. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No
28. Have you volunteered to or been asked to participate in a rehabilitation program for impaired dentists? ☐ Yes ☐ No
29. Have you now or have you ever had a chronic illness or physical limitation that impairs or could tend to impair your ability to practice dentistry? ☐ Yes ☐ No
30. Have you been charged with or convicted of a crime (other than a minor traffic violation)? ☐ Yes ☐ No
31. Have fee complaints or professional relations complaints been registered against you with your dental society/association or state licensing authority within the past five years? ☐ Yes ☐ No
32. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy? ☐ Yes ☐ No
33. Has any insurance carrier ever declined to offer professional liability insurance to you? ☐ Yes ☐ No
34. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
    If "Yes", has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No
35. Are you aware of any circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No
    If "Yes", has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No

NOTE: If you answered yes to question 34 or 35, please provide the following information to complete and expedite our underwriting review:

A full typewritten narrative, in your own words, of each situation, including a statement of facts at issue (include names, dates, places, your diagnosis and treatment of the case)

A copy of the petition filed against you, and/or any judgment or settlement if available

A copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim

We may ask for additional information as needed. Please be as thorough as possible in order to expedite the review of your application.

36. List names of all professional liability insurance carriers that you have been insured with for the last 10 years, dates of coverage and reasons for change: _____
    _____
    _____
37. Why did you choose LAMMICO? _____
    _____
38. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes?
    _____

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39. What is your existing form of insurance? ☐ Claims-Made ☐ Occurrence ☐ None Carried

40. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement ("tail" coverage)? ☐ Yes ☐ No

    (a) If no, are you applying for prior acts coverage from LAMMICO? ☐ Yes ☐ No

    If *no*, I realize that not purchasing the "tail" from my current carrier can result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy I am purchasing from LAMMICO will not provide prior acts coverage.

    Initial here _____

    (**LAMMICO will give consideration for prior acts only to those physicians who have practiced medicine exclusively in Louisiana**. If you qualify, please submit a copy of your current policy showing the retroactive date and a current certificate of enrollment from the Louisiana Patients' Compensation Fund.) Any claims or any circumstances that might reasonably lead to a claim or suit must be reported to your present carrier prior to the requested effective date of this insurance.

41. Retroactive date used by your existing carrier: _____

    NOTE: To prevent possible gaps in your claims-made coverage, either a reporting endorsement ("tail") or prior acts coverage must be purchased.

Question No.	Remarks (Attach additional sheets, if necessary)

Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I understand that the statements and answers will be relied upon by LAMMICO and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize release of my name, business address, policy and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

_____ _____

Applicant Signature **Date**

LAMMICO is required by LA Revised Statute 40:1424, to include the following on this application:

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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

CERTIFICATES OF INSURANCE

List any facilities/locations where you hold or are applying for staff privileges. Place an *X* in the box in front of each location requiring a certificate of insurance. Also list other entities (i.e., credentialing organizations, managed care entities, etc.) requiring certificates of insurance.

	Institution Code (LAMMICO Use Only)
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CLAIM/SUIT/COMPLAINT INFORMATION ADDENDUM

If additional space is required, please photocopy this form as needed. Please type or print in black ink.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

Name of applicant: _____

Patient's Initials: _____ Age: _____ Sex: _____ Date of incident: _____
(MM/DD/YYYY)

Insurance company defending your claim : _____ Policy No. _____

Location of Incident: _____ City: _____ State: _____
(Hospital, Office, Etc.)

Procedures Performed: _____

Allegations and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.). If you already have a written narrative, please attach it to this form. Please attach a second sheet of paper if additional space is required.

_____
_____
_____
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_____
_____

Co-defendants: _____

Present Status

Medical review panel date: _____ Panel Opinion: ☐ Favorable ☐ Unfavorable ☐ Issue of Fact

Suit Filed: ☐ Yes ☐ No If *yes*: Month _____ Year _____

Court Trial: ☐ Yes ☐ No Verdict: ☐ Defense Verdict ☐ Plaintiff Verdict Amount: $_____

Settlement Out of Court: ☐ Yes ☐ No If *yes*: Month _____ Year _____ Amount: $_____

☐ Claim settled without indemnity payment on your behalf ☐ Claim is pending ☐ Claim dismissed or withdrawn

Amount in reserve by insurance company $_____
Total amount paid to claimant on your behalf $_____
Total amount paid to claimant for all defendants $_____

The Applicant understands that the information submitted herein becomes part of the Professional Liability Application for insurance and declares that no material facts have been suppressed or misstated.

_____ _____
Applicant Signature in Full Date