PSIC | RPG Association

Dental Professional Locum Tenens Application

A. AGENCY INFORMATION

Agency Name ______________________________

Agency License Number: ______________________________

Address: ______________________________
Street City State Zip

Office Phone: (________)____________________ Email Address: ____________________
Your email address will never be sold. It will be used to send you important messages.

B. APPLICANT INFORMATION

Name: ______________________________
First Middle Last

❑ Female ❑ Male Social Security No. (last 4 digits)____________________ Date of Birth:______________
MO/DAY/YR

Name of NCMIC Insurance Company (NCMIC) Insured for whom you are substituting: ____________________
Policy Number: ______________

Practice Location of where you will be working:______________________________

Please indicate the exact dates requested for coverage, not to exceed the maximum number allowed per policy period. If a range of dates are used, do not include dates the office is closed or dates you will not be in the office, so those dates do not count against the maximum number allowed.

Dates of Coverage: ______________________________
If additional space is needed, please use a separate piece of paper. This application will stay on file for three years.

Locum Tenens coverage is a benefit provided to our insured. As the temporary substituting dentist, the Locum Tenens, understands and agrees that services provided must be similar to those provided by the NCMIC insured dentist.
The substituting dentist will share the limits of the NCMIC insured dentist.

C. EDUCATION

School of Graduation: ______________________________
Name State Country

Degree (DMD, DDS,BDS): ____________________ Year: ____________________

Clinical Based Training, Residency, Fellowship (Facility, State): ____________________

Specialty Type: ____________________ Date Completed: ______________

Additional Training: ______________________________

Specialty Type: ____________________ Date Completed: ______________

D. LICENSURE

Please list all states in which you currently hold or have held a license:

State: ______________ License No:______________ Issue Date:______________

State: ______________ License No:______________ Issue Date:______________

State: ______________ License No:______________ Issue Date:______________

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E. PRACTICE ACTIVITIES

1. Primary dental specialty: ______________________________ % of practice: __________
   If your dental specialty is not consistent with the NCMIC insured's specialty, please describe the duties you will be performing while substituting for the NCMIC insured. ______________________________

2. Do you currently have malpractice insurance? ❑ Yes ❑ No
   If yes, does your policy provide coverage to you while working as a locum tenens? ❑ Yes ❑ No

   Note: if your policy does provide coverage, there is no need for this coverage from NCMIC

   Please provide the name of your current carrier: ______________________________

F. HISTORY

1. Please provide information on each professional liability insurer you have had for the last 10 years. Please provide this information in chronological order:

Dates	Insurer	Coverage Type	Tail Coverage Purchased?	Any Claims?
		❑ Occurrence ❑ Claims-Made	❑ Yes ❑ No	❑ Yes ❑ No
		❑ Occurrence ❑ Claims-Made	❑ Yes ❑ No	❑ Yes ❑ No
		❑ Occurrence ❑ Claims-Made	❑ Yes ❑ No	❑ Yes ❑ No

2. Are you now, or have you ever practiced without professional liability coverage? ❑ Yes ❑ No
3. Has any insurance company ever declined, failed to renew or conditionally renewed, restricted or cancelled your professional liability policy? (Missouri residents, skip this question): ❑ Yes ❑ No
4. Have you ever had your dental license, hospital privileges, DEA License or reimbursement privileges refused, denied, revoked, suspended, investigated, restricted, subject to reprimand, placed on probation or voluntarily surrendered? ❑ Yes ❑ No
5. Have any complaints or actions been brought against you alleging sexual misconduct? ❑ Yes ❑ No
6. Have you incurred or become aware of or are you being treated for a condition that impairs your ability to practice dentistry to any degree? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics or other controlled substances, etc.) ❑ Yes ❑ No
7. Have you ever been indicted for, charged with, or convicted of any act committed in violation of any law or ordinance other than minor traffic offenses? ❑ Yes ❑ No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.

G. LOSS INFORMATION

1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services?* ❑ Yes ❑ No

   If yes, please indicate the number of each: Number of pending suits: __________ *Number of closed claims:* __________

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
   Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient? ❑ Yes ❑ No
   A letter from an attorney regarding your treatment of a patient? ❑ Yes ❑ No
   A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis? ❑ Yes ❑ No
   Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? ❑ Yes ❑ No

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G. LOSS INFORMATION (CONTINUED)

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier?.. ❑ Yes ❑ No

   If yes, please attach a current loss run for each carrier, as appropriate.

   If no, please explain why these circumstances were not reported: ____________________

** For the purposes of this section the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.*

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.

H. SIGNATURE REQUIRED

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that NCMIC Insurance Company (NCMIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by NCMIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by NCMIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to NCMIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by NCMIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify NCMIC of any changes in my practice of dentistry within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state dental license, DEA license or any hospital privileges;
- Any mental or physical condition that materially impairs my ability to practice dentistry, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to NCMIC during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

Connecticut and Nevada Residents: 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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Florida Residents: 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.

Dental malpractice insurance is offered through PSIC RPG Association. Coverage is underwritten by NCMIC Insurance Company.

I understand and agree to the terms and conditions of coverage provided to this Locum Tenens in accordance with my policy.

____________________ ____________________

Signature of Applicant Date

____________________ ____________________

Signature of NCMIC Insured Date

Mail to:
14001 University Avenue
Clive, Iowa 50325-8258

Questions:
Phone: 800-864-8026
Fax: 800-600-8170

Email: dentalsubmissions@ncmic.com

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