KaMMCO
Kansas Medical Mutual Insurance Company

623 S.W. 10th Avenue
Topeka, Kansas 66612
800-232-2259 | 785-232-2224
www.KaMMCO.com

Dentist Application for Claims-Made Professional Liability Insurance
New Business

Requested Effective Date: _____

APPLICATION INSTRUCTIONS AND REQUIRED INFORMATION

- Please answer all questions completely and accurately.
- Please complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, please use the Comments Section at the bottom of the application form, or attach separate documentation.
- Please sign and date the application where indicated.
- Please provide claim information for the last five years and include current company loss runs.

A. Applicant Information

Agency Name (if applicable)		
Name of Applicant (First, Middle, Last)	☐ Dentist ☐ Other Specify Other:	Gender ☐ Male ☐ Female
Applicant's Business Address (Street, City, State, Zip Code)		County
Business Phone:	Fax:	E-mail:
Date of Birth:	Social Security Number:	
Applicant's Home Address (P.O. Box not accepted) (Street, City, State, Zip Code)		
Home Phone:	Cell Phone:	Personal E-mail:
Mailing/Billing Address: ☐ Home ☐ Business ☐ Other (specify) Other:		Business Manager/Contact Person:
Telephone:	Fax:	Business E-mail:

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other

Are you a member of the Kansas Medical Society? ☐ Yes ☐ No
If no, please complete the attached Kansas Medical Society membership application.
Note: Membership in good standing in the Kansas Medical Society is required for coverage with KaMMCO.

B. Current Coverage

Existing Form of Insurance: ☐ Occurrence ☐ Claims-Made If Claims-Made, what is your retroactive date?

Specify below insurance coverage for the past five years:

Carrier name	Policy #	Coverage Dates	Limits	Retroactive Date

C. Requested Coverage

Limits of Liability (Limits are expressed as per claim and annual aggregate)

☐ $100,000/$300,000 ☐ $250,000/$750,000 ☐ $500,000/$1,000,000 ☐ $1,000,000/$3,000,000
☐ $200,000/$600,000 ☐ $300,000/$900,000 ☐ $500,000/$1,500,000

D. Practice Information

1. If you are employed, indicate the name of your employer:

2. If you are an independent contractor, name each entity with which you have contracted dental services:

3. List each professional corporation, association, partnership or other health care related entity in which you have an ownership:

Name	Description of Interest	% or Practice

Complete one Corporate Health Care Application for each organization listed above, if coverage is desired.

4. If you, as an individual, employ or contract other medical professionals, complete the following:

Type	Number	Employment	Current Insurer
Licensed Dentists, Oral Surgeons or MDs		☐ Employee ☐ Contractor	
Dental Hygienist		☐ Employee ☐ Contractor	
Technicians		☐ Employee ☐ Contractor	
Nurses – including CRNAs		☐ Employee ☐ Contractor	

E. Education / Training / Work Experience

1. School of Graduation:	City & State:	Year of Graduation:

2. How many years have you been practicing dentistry? Professional Degree(s):

3. Are you certified by an approved specialty board? ☐ Yes ☐ No If yes, certifying board name(s): _____
Date(s) of initial certification: Date(s) of recertification:

4. If you are not certifed, are you board eligible? ☐ Yes ☐ No If yes, date eligibility expires:

5. List each state where you are licensed to practice and license number:

State	License Number

6. List all places where you have practiced your profession during the past five years:

Facility/Practice/City/State	**Dates** (month/year to month/year)
	to
	to
	to
	to

7. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No

If "yes", describe changes:

F. Classification

1. Character of Practice: (check all that apply and indicate percentage of practice)

____% General Dentistry ____% General Dentistry limited to (e.g., TMJ, Implants): _____

____% Dental Public Health ____% Periodontics ____% Endodontics ____% Oral Pathology

____% Pediatric Dentistry ____% Oral Surgery ____% Prosthodontics ____% Orthodontics

____% Faculty – Intramural ____% Faculty – Non-Intramural

NOTE: THESE QUESTIONS INQUIRE AS TO YOUR USE OF ANESTHESIA AND ANALGESIA. PLEASE MAKE CERTAIN YOU READ AND ANSWER ALL PARTS CAREFULLY. IF THE ANSWER TO ANY PART OF QUESTIONS 2 THROUGH 4 IS "YES", PLEASE COMPLETE THE ANESTHESIA/ANALGESIA QUESTIONNAIRE SEGMENT OF THIS FORM.

2. Do you limit your practice to local anesthesia and/or oral medication?	☐ Yes ☐ No
3. Is nitrous oxide used when treating patients?	☐ Yes ☐ No
4. Are you treating patients who are under conscious sedation? (Note: For purposes of this insurance application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation)	☐ Yes ☐ No
5. Are you treating patients who are under general anesthesia (deep sedation)?	☐ Yes ☐ No

G. Underwriting Questions

Explain any "yes" answers to the following questions in the Comments section.

1. Has your license to practice dentistry ever been denied, revoked, suspended, voluntarily surrendered, or subject to investigation or probationary terms in any jurisdiction?	☐ Yes ☐ No
2. Has your license to prescribe or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered, or subject to investigation or probationary terms?	☐ Yes ☐ No
3. Has your membership in any dental society, specialty board, or professional organization ever been denied, suspended, revoked, voluntarily surrendered or subject to investigation or probationary terms?	☐ Yes ☐ No
4. Have you ever been or are you currently the subject of investigation, disciplinary proceedings or reprimand by any administrative agency, licensing entity, dental society, hospital or professional organization?	☐ Yes ☐ No
5. Has any application for hospital staff privileges ever been denied or granted with restrictions or conditions?	☐ Yes ☐ No
6. Have your hospital privileges ever been modified, revoked or non-renewed or have you been subject to probation or disciplinary action related to your hospital privileges?	☐ Yes ☐ No
7. Have you ever had board certification refused or revoked?	☐ Yes ☐ No
8. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	☐ Yes ☐ No
9. Has your professional liability insurance ever been declined, canceled, refused, non-renewed, or issued on special terms?	☐ Yes ☐ No
10. Has any administrative agency, licensing entity, hospital, or professional organization ever requested you to be examined or evaluated by a physician because of an alleged mental condition, alcohol abuse, or drug dependency?	☐ Yes ☐ No

11. Have you ever had an illness or physical disability that impairs or could tend to impair your ability to practice dentistry or could put your patients at risk? (e.g. alcoholism, convulsive disorders, Hepatitis B, HIV positive, mental illness, multiple sclerosis, narcotics addiction, rheumatoid arthritis, etc.) ☐ Yes ☐ No

If "yes": a) state illness or disability in Comments Section; and b) include a statement from your physician with complete details of your illness or disability and attesting to your fitness to practice.

12. Have you ever been treated for alcohol or drug addiction or mental illness? ☐ Yes ☐ No

H. Claim Information

Explain any "yes" answers to the following questions in the Comments section.

1. Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors arising out of the performance of professional services rendered or which should have been rendered by any person for whose acts or omissions the Applicant is legally responsible for? ☐ Yes ☐ No

If "yes", indicate the number of previous and/or pending claims or suits:

Please complete the Claim/Suit Information Worksheet for each claim above. Make additional copies as needed.

I. Comments

Section & Question	Explanation

Execution of this application by the applicant does not bind Kansas Medical Mutual Insurance Company (KaMMCO) to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

I understand membership in good standing in the Kansas Medical Society is required for coverage with KaMMCO.

If a policy is issued, the policy will be issued on a claims-made basis and will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy.

The applicant represents the statements and answers made herein are true, and makes the same for the purpose of inducing KaMMCO to issue the policy for which application is hereby made. It is understood that this entire policy shall be void if, whether before or after a loss or claim, the applicant has intentionally concealed or misrepresented any material fact or circumstance concerning the insurance or subject thereof.

I hereby authorize KaMMCO to release the information on this application and associated underwriting information to any insurability committee(s) established by the American Dental Association and/or my state dental society. I also consent to the review of any incident or occurrences likely to result in a malpractice allegation and claims alleging malpractice by any claim review committee(s) established by the American Dental Association or my state dental society.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by KaMMCO as may be authorized by law.

_____ _____

Signature of Applicant Date

ANESTHESIA ADDENDUM

For purposes of this questionnaire, the following definitions of conscious sedation and general anesthesia are provided:

CONSCIOUS SEDATION – is a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof. For purposes of this insurance application, the use of nitrous oxide solely as an analgesic is not considered conscious sedation.

GENERAL ANESTHESIA (to include deep sedation) – is a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

ANESTHESIA QUESTIONNAIRE (Complete ONLY if you have answered "Yes" to questions F. 2 through 5). In this questionnaire, "anesthesia" means any form of inhalation, intravenous or other intramuscular anesthesia or analgesia and/or any combination thereof.

A. Type of anesthesia/analgesia used when treating patients under conscious sedation: (please specify) (When used in combination with other anesthetic or analgesic agents);

1. Inhalation: _____ Nitrous Oxide (when used in combination with other anesthetic or analgesic agents): _____ Other: _____

2. Intravenous: _____

3. Intramuscular (including submucosal): _____

4. Combination: _____

5. Where are conscious sedation procedures performed?
_____ Office Only _____ Hospital Only _____ Both Office & Hospital

B. Type of anesthesia/analgesia used when treating patients under general anesthesia: (please specify) (When used in combination with other anesthetic or analgesic agents);

1. Inhalation: _____ Nitrous Oxide (when used in combination with other anesthetic or analgesic agents): _____ Other: _____

2. Intravenous: _____

3. Intramuscular (including submucosal): _____

4. Combination: _____

5. Where are conscious sedation procedures performed?
_____ Office Only _____ Hospital Only _____ Both Office & Hospital

C. Please indicate the number of years you have been using conscious sedation or general anesthesia in your office:

D. How many times (on the average) per week do you use conscious sedation or general anesthesia in your office?

E. Please specify the type of major and minor surgical procedures performed while treating patients under conscious sedation or general anesthesia:

Major - _____

_____

Minor - _____

_____

F. Please indicate if you have had the following training and if so, the date and period of time spent in training:

Hospital training in the use of general anesthesia? _____

University training in the use of general anesthesia? _____

Hospital training in the use of general sedation? _____

University training in the use of conscious sedation? _____

Other types of training (i.e., Continuing Education programs): _____

_____

_____

G. I am certified by, or am a member of, the following organizations that require training in general anesthesia: ☐ AAOMS ☐ ABOS ☐ Fellow, ADSA ☐ Member, ADSA
☐ Other (please specify):

_____

_____

H. I am equipped and trained to use the following emergency procedures:
☐ Positive Pressure Endotracheal Respiratory Assistance
☐ Intravenous Emergency Medications
☐ External Cardiac Massage
☐ Other (please specify): _____

I. Please indicate the type of emergency equipment you have in your office: _____

_____

_____

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Claim Information Worksheet (Please make additional copies if necessary)

No Claims: ☐ *A signature is required regardless of claim history*

Patient's Name: _____
(Last, First, Middle)

Gender: ☐ Male ☐ Female

Allegation: _____

_____

_____

Date of Incident: _____ **Date reported:** _____

Insurance Carrier: _____

Was a lawsuit filed? ☐ Yes ☐ No Are/were you the primary defendant? ☐ Yes ☐ No
If "No", please describe your involvement in patient care: _____

_____

_____

_____

_____

Additional defendants: _____

Location of occurrence: _____

Claim Status:
☐ Open ☐ Closed Date Closed: _____

If open, indicate reserve amount: $ _____

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment
b. Amount of settlement or judgment: $ _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

_____ _____
Signature Date

(Signature Required)