

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 PSIC 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 PSIC insured dentist. The substituting dentist will share the limits of the PSIC 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: _____

E. PRACTICE ACTIVITIES

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

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?
		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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 Professional Solutions Insurance Company (PSIC) 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 PSIC 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 PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, 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 PSIC 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 PSIC 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 PSIC during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Colorado, Maryland, New York, New Jersey, Oregon, Pennsylvania, Tennessee, Virginia and Washington: 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.

Colorado residents: 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.

Maryland residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 York 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (11 NYCRR 86.4(a)) {parallel citation Regulation 95}

New Jersey residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oregon 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, may be subject to prosecution for insurance fraud.

Pennsylvania 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee, Virginia and Washington residents: 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.

Malpractice Insurance is underwritten by Professional Solutions 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 PSIC Insured

Date



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

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

Email: dentalsubmissions@psicinsurance.com