

***Dentists and Oral Surgeons Professional Liability
Insurance Application***

South Carolina Medical Malpractice Liability Insurance
Joint Underwriting Association
Assessable Policy



For assistance, please contact Marsh, the Program Administrator, at:
864-240-5400

SCJUA
c/o Marsh USA Inc.
550 South Main Street, Suite 600
P. O. Box 128 (29602)
Greenville, SC 29601
Fax: 864-240-2750

Return Completed Application to:

Broker Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

Contact Name: _____

E-mail: _____

Important: No action can be taken on this application until it is fully completed. "Fully completed" means you have answered all questions, provided separate explanations where necessary, signed and dated in the appropriate places, and attached the following documents:

New Business or Rewrite:

1. Copy of current declarations page showing type of policy form and current retroactive date; and,
2. Verification of or intent to obtain Reporting Coverage (tail) from current carrier; and,
3. Loss run from all previous Professional Liability insurers for not less than the prior 10 years, or since you first became licensed, whichever is greater. The evaluation or date of issue of such loss runs may not be more than sixty (60) days old; and, a National Practitioner Databank report. (www.npdb-hipdb-hrsa.gov or 1-800-767-6732)
4. Copy of Curriculum Vitae (CV); and, copy of business letterhead.
5. **Coverage is not bound until the JUA receives payment in full.**

For JUA Use Only	Rating Class		Other Charges		Policy Fee	
	Endorsements				Final Premium	

SECTION I - PERSONAL INFORMATION

A. Full Name of Applicant:

_____ DMD Male
 First Middle Last DDS Female

B. Home Address:

_____ County _____
 Number & Street Suite

 City State Zip

 () ()
 Telephone Number Fax Number

C. Date of Birth (MDY): _____ D. Social Security Number (last 4 only): _____

E. May we communicate with you by e-mail? Yes No If "Yes", E-Mail Address: _____

SECTION II - PRACTICE LOCATION(S) INFORMATION

A. Primary Practice Address:

_____ County _____
 Number & Street Suite

 City State Zip

 () ()
 Telephone Number Fax Number

B. Secondary Practice Address:

_____ County _____
 Number & Street Suite

 City State Zip

 () ()
 Telephone Number Fax Number

C. Preferred Mailing Address: Home Primary Office Secondary Office

D. May we communicate with you by fax? Yes No

E. Do you have additional office locations not listed above? Yes No
 If "Yes", list in *Additional Comments Section*.

SECTION III - DENTISTS AND ORAL SURGEONS COVERAGE SELECTION INFORMATION

Important Note: SCJUA offers individual dental and oral surgeon limits of liability of \$200,000 each Medical incident / \$600,000 annual aggregate. For additional coverage, please contact the SC Patients' Compensation Fund at 803-896-5290 or www.spcpf.com

New Policy Re-write Renewal Prior Policy #: _____

A. Type:

- Occurrence Coverage
- Claims-Made Coverage without Prior Acts Coverage. (Check the one appropriate response below):
- An Extended Reporting Endorsement (tail coverage) is automatic or will be purchased from my current carrier.
Note: if previously insured on a claims-made basis, failure to obtain an Extended Reporting Endorsement will leave you without complete coverage.
 - My current policy is on an occurrence form.
- Claims-Made Coverage with Prior Acts Coverage (This is subject to restrictions.)

Requested retroactive date (M/D/Y): _____ 12:01 a.m.
(This date cannot be greater than the retroactive date shown on your current policy.)

B. Effective Date: Requested Coverage Effective Date: (M/D/Y): _____ 12:01 a.m.
(This date cannot be earlier than the expiration date of your current policy. Annual policy terms will begin and end on the same month and day.)

C. Expiration Date: _____

SECTION IV - RATING INFORMATION

- A. What is your present specialty? _____ Percentage of Practice? _____ %
- B. Have you ever failed any licensing or Board Certification or recertification examination? Yes No
If "Yes", provide name(s) of exam(s) and number of times failed in the *Additional Comments Section*.
- C. Have there been any changes in your specialty, classification, or practice activity within the past five years? Yes No
If "Yes", describe the nature of the change(s) in the *Additional Comments Section*.

D. SPECIALTY CLASS

Please check the appropriate class. Any Procedure or Anesthesia in a higher class would make the higher class applicable.

Class	Procedure and / or Specialty	Anesthesia	Check Appropriate Class
1	General Dentistry Endodontics Pediatrics Prosthodontics Orthodontics Periodontics / Non-Osseous Surgery, Non-Advanced or Non-Refractory Progressive Periodontitis Implant Prosthesis / Non-Surgical Removal of Impacted Wisdom Teeth Soft Tissue Only	In the office: Local Nitrous Oxide Oral Conscious IV Administered in the hospital by other than an insured or insured's employee: General Deep Intra Muscular (I.M.)	<hr/> (1) (80211)
2	Periodontics / Osseous Surgery, Advanced or Refractory Progressive Periodontitis Removal of Impacted Wisdom Teeth, Other than Soft Tissue	Conscious I.M. in the office	<hr/> (2) (80223)
2A	Implants / Surgical		<hr/> (2A) (80224)
3	Oral Surgeon Maxillofacial Surgery	General Anesthesia and / or Deep Sedation given in a dosage to render the patient unconscious and done in the office, or in a hospital if administered by an insured or insured's employee.	<hr/> (3) (80210)

COMPLETE THIS SECTION ONLY IF YOU ARE THE EMPLOYER AND YOU DO NOT HAVE A SEPARATE PROFESSIONAL ASSOCIATION MALPRACTICE LIABILITY POLICY

E. Please list all dentists/oral surgeons who are your employees and/or independent contractors (list the full name, status, current professional liability carrier). If the employee or independent contractor is not insured with the SC JUA, please attach a copy of their Declaration Sheet or Certificate of Insurance.

An individual employer may incur a legal responsibility for the actions of his/her employee(s). Additional charges shall be made for the employee(s) to reflect this exposure. The additional charge does not contemplate that coverage will be provided to the employee(s), but only contemplates liability imparted to the employer. Do you employ any of the following?

- 1. Employed Dentist Yes No How Many? ____
- 2. Employed Oral Surgeon Yes No How Many? ____
- 3. Employed Surgical Technician Yes No How Many? ____
- 4. Employed Anesthesiologist or Nurse Anesthetists Yes No How Many? ____
- 5. Other (please specify) _____ Yes No How Many? ____

If yes to any of the above please provide names and policy numbers _____

F. ADDITIONAL INSURED ENDORSEMENT: "STAFF COVERAGE ENDORSEMENT"

Do you wish to include your other employees as additional insureds? (Staff Coverage Endorsement includes hygienist, dental assistances, and administrative staff) Yes No

SECTION V - PRACTICE ORGANIZATION INFORMATION

A. Please check the boxes in A1 and A2 that best describe your practice affiliations(s):

A1. Employment Status:

- Employee
- Shareholder/Partner
- Independent Contractor
- Solo Unincorporated/Sole Proprietor
- Intern/Resident/Fellow
- Other: _____

A2. Entity Type

- Professional Association
- Multi-Shareholder Corporation, Partnership, LLC
- Solo Incorporated – No employed or contracted physicians
- Hospital Owned
- Government Owned
- Industrial
- Other: _____

B. Name of practice/entity organization: _____

C. Is the purpose of the entity other than a dental office practice? Yes No

D. Do you have any office or expense sharing arrangements with any other dentist(s)/oral surgeon(s) or practice group(s) not disclosed? Yes No

E. Are there any subsidiaries of this business entity that provide health care related services? Yes No

F. Is the entity eligible to be licensed to provide medical professional services? Yes No
If "Yes", attach a copy of the license to the application.

G. Does the entity name in question "B" above currently maintain professional liability coverage? Yes No
Is this form of coverage Occurrence or Claims-Made?
If Claims-Made, what is the retroactive date used by the current carrier (MM/DD/YY): _____

H. Date of Incorporation (MM/DD/YY): _____ J. Corporate Tax Identification Number: _____

I. Do you desire coverage for the business entity named in question "B" above? Yes No
If "yes" do you wish to share your individual policy limits with this business entity? Yes No
If "no" and separate limits are desired, you must purchase a separate policy. See JUA Form A100 (Rev. 11-2006).

SECTION VI - PRACTICE INFORMATION

A. List all states where you are licensed to practice dentistry and your license numbers:

State	License Number	Status Code	% of Patients seen, examined or treated in each state

Status Code - A = Active, I = Inactive, P = Pending, T = Temporary

80% of your practice must be in South Carolina. 20% may be in border areas such as Rock Hill / Charlotte, North Augusta / Augusta or Hilton Head / Savannah. Incidental exposure in states other than border states must have prior approval by the JUA.

B. DEA License Number: _____ NA

C. Indicate the average weekly numbers, under each of the following categories

- i. Number of scheduled patients seen per week? _____
- ii. Number of walk-in patients seen per week? _____
- iii. Number of hours worked per week? _____

D. Are you permanently retired from the practice of dentistry? Yes No

E. Are you employed full-time or part-time by the Federal, State, or Local Government or are you in active duty in the military services?
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and note if coverage is provided by the Federal Tort Claims Act. Attach verification of coverage, if applicable.

F. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates, Yes No
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

G. Do you provide clinical or administrative services to any free clinic, lab, nursing home, or similar facility? Yes No
 If “Yes”, do you serve as the Medical Director? Yes No
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage, if applicable.

H. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No
 If “Yes”, do you have coverage under a separate policy for this exposure? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage, if applicable, and copy of the indemnification agreement provided by the pharmaceutical company.

I. Are you engaged in “moonlighting” activity or perform activities other than reported above which will be covered by another professional liability policy? Yes No
 If “Yes”, provide details in the *Additional Comments Section* and attach verification of coverage.

SECTION VII - DENTAL TRAINING AND WORK HISTORY INFORMATION

Name of Professional School(s) Attended	Location	Degree	Date Graduated

List all locations (City and State) where you have practiced in the last five years. List most recent location first. Do not include training programs but include all moonlighting positions.	Start Date and End Date (m/y)

A. Are you entering private practice for the first time? Yes No

SECTION VIII - PROFESSIONAL INFORMATION

Please answer YES or NO. If your answer is YES to any of the following questions indicate the date and state (if applicable) where action occurred. Please give full details on the Additional Comments Section.

- A.**
1. Have you had a denial, restriction, suspension, probation, or revocation of privileges by a hospital or other health care facility? Yes No Date _____ State _____
 2. Have you entered into any consent agreement related to your privileges with any formal committee of a hospital or other health care facility? Yes No Date _____ State _____
 3. Have you had a denial, restriction, suspension, probation, or revocation of your privileges to prescribe medications by the Drug Enforcement Administration? Yes No Date _____ State _____
- B.**
1. Have you had a denial, restriction, suspension, probation, or revocation of your license to practice medicine by any State Licensing Board or been issued a public reprimand? Yes No Date _____ State _____
 2. Have you entered into a consent agreement related to your license with any State Licensing Board or any other medical review committee in your field of practice? Yes No Date _____ State _____
 3. Have you been convicted of or pled guilty to any misdemeanor or Driving Under the Influence (excluding minor traffic violations)? Yes No Date _____ State _____
 4. Do you prescribe or administer substances that are not FDA approved, perform procedures that are considered experimental, or perform procedures for which you do not have appropriate training or are not board certified?
 Yes No
 5. Have you had an injury, illness, or other event occur that may impair your ability to practice? Yes No
Date _____
 6. Have you been declined, non-renewed, or cancelled by an insurance carrier with cause (excluding market withdrawal)?
 Yes No Date _____ Insurance carrier _____
 7. Have you experienced a medical incident or alleged injury in which there is no reasonable defense and failed to report it to your insurance carrier within 30 days of the occurrence?
 Yes No Date of incident/alleged injury _____
Date reported _____ Insurance Carrier _____
 8. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness, including but not limited to depression? Yes No
If "Yes", has a relapse occurred following your initial treatment? Yes No
- C.**
1. Have you been found by a court of law or State Licensing Board to have participated in any sexual misconduct with a patient? Yes No Date _____ State _____
 2. Have you been convicted of or pled guilty to a felony, convicted of or pled guilty to a criminal offense for which one of the elements is fraud or misrepresentation, or have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment or sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? Yes No
Date: _____ State: _____
Note: Answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.
 3. Have you been accused of or been found to have altered health care records?
 Yes No Date _____

SECTION IX - PROFESSIONAL LIABILITY INSURANCE HISTORY INFORMATION

- A. Have you ever practiced without professional liability coverage? Yes No

- B. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage (tail coverage)? NA Yes No
- C. Have you ever had your request for coverage denied, your policy cancelled or non-renewed or had a policy issued to you that contained restrictions or special exclusions? Yes No
- If questions A–C are answered “Yes”, please provide a detailed description in *Additional Comments Section* or on a separate sheet.
- D. If prior carrier was not the SC JUA, please provide information on your Professional Liability Insurance carrier for the previous five years.

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date					
Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Rating Classification					

SECTION X - CLAIMS INFORMATION

Important information regarding questions Section IX A and B

- The word "claim" and "circumstance" as used in Questions A and B following refer to:
 - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any professional corporation or partnership including but not limited to: a letter from an attorney or a patient requesting medical records or expressing dissatisfaction regarding your medical treatment, or intent to pursue a claim or file a lawsuit against you, a patient or family member's dissatisfaction with the outcome of a procedure, treatment, or diagnosis. and/or any other circumstances that might reasonably lead to a claim or suit.
- Please complete the attached *Malpractice Claims History Explanation Form* for each case reported in A 3.

- A. Are you now or have you ever been involved in a malpractice claim or suit, either directly or indirectly? Yes No

If “Yes”, please indicate number of cases below:

- Where (County and State)**
1. Current number open: _____
2. Current number closed: _____
3. Total number of cases: _____ (1 +2)

- If “Yes” have all been reported to your current or prior professional liability insurer? NA Yes No

- B. Other than the claims/suits indicated in question A above, are you aware of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failure to render professional service which may give rise to a claim even if you believe the claim or suit would be without merit? Yes No

If "Yes", how many? _____ Please attach details of each circumstance.

If "Yes" have all been reported to your current or prior professional liability insurer? NA Yes No

If all have **not** been reported to your current or prior professional liability insurer please explain in Additional Comments Section or on separate sheet.

- C. Have you ever had an adverse outcome that may have resulted in the following:
- any neurological, sensory, or systemic deficits to a patient (such as brain damage, permanent paralysis, loss of sight or hearing, etc.) Yes No
 - limitations on a patient's activities of daily living Yes No
 - the death of a patient. Yes No

SECTION XI - MALPRACTICE CLAIMS HISTORY EXPLANATION FORM**Malpractice Claims History Explanation**

Please complete one for EACH such case, potential claims, or suit reported in Section XII - A and B. Please photocopy this form. All questions must be answered or marked not applicable (NA).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Carrier: _____ File Number: # _____ Telephone #: _____

Address of Insurance Carrier: _____

Date Reported to Insurance Company: _____ Date of incident, treatment and or surgery: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No
What is the status of this matter? Open Closed If "closed" was matter closed with your consent? NA Yes No

(Check applicable description below)

- | | | |
|---|---|---|
| <input type="checkbox"/> Incident report only | <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Suit filed but dropped by claimant |
| <input type="checkbox"/> Summary judgment in your favor | <input type="checkbox"/> Jury verdict in your favor | <input type="checkbox"/> Jury verdict in favor of the plaintiff |
| <input type="checkbox"/> Suit settled out of court | <input type="checkbox"/> Suit filed awaiting mediation | <input type="checkbox"/> Suit filed awaiting court action |

If closed, amount of total loss payment paid on your behalf: \$ _____ Date paid: _____

If open, amount of case value (loss reserve) established by carrier: \$ _____

SECTION XII - ADDITIONAL COMMENTS SECTION

<u>Section</u>	<u>Question</u>	<u>Explanation/Comments</u>
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____

SECTION XIII - SCDA RISK MANAGEMENT DISCOUNT, AGREEMENT AND AUTHORIZATION

A. FIRST YEAR RISK MANAGEMENT DISCOUNT

(Dentists that are subject to experience rating / schedule rating are not eligible for this discount.)

_____ I am beginning my first year of practice since the completion of my dental training, and I agree to qualify
Initial here for a 25% first year premium reduction subject to a maximum \$2,000 premium reduction by completing the
if applicable South Carolina Dental Association's Risk Management Program during my first year of practice. This discount is
in the form of an endorsement with a return premium credit issued upon receipt of SCDA certificate of completion
for the Risk Management program. (Please contact SCDA to obtain further information regarding the risk
management seminar.)

**B. I hereby represent that I have no knowledge of any professional liability suit or stated demand for damages which has
been asserted against me, or of any occurrence or circumstance likely to result in such a suit or demand for damages,
except as described herein.** _____ **Initial here**

C. It is important to understand the difference between Occurrence Coverage and Claims-made coverage.

1. Occurrence Coverage:

I understand that occurrence coverage will respond to incidents that occur during the policy period without any consideration
for the date a claim is filed with the insurance company. _____ **Initial here**

2. Claims-Made Coverage:

I understand that claims-made coverage will respond to incidents that take place on or after the prior acts date ("retroactive
date") of the policy and which are reported to the insurance company during the policy period. Claims-made coverage
involves a step process with the premium increases over the first five years of coverage following the retroactive date in
increments proportional to the claims reporting for that experience. The initial premium and subsequent years' premium are
lower than an occurrence policy. However, as of the fifth year the claims made premium reaches a mature level and premium
adjustments are based on annual rate changes only. If coverage is discontinued, a Reporting Endorsement ("Tail Coverage")
must be purchased to provide coverage for claims which have occurred but are not yet reported. _____ **Initial here**

**D. Signing this application does not bind the JUA to complete the insurance but it is agreed that I hereby warrant that the
information contained in this application is accurate and complete to the best of my knowledge. I understand that this
application shall be considered a part of the terms and conditions of my policy with the South Carolina Medical
Malpractice Liability Insurance Joint Underwriting Association and that my JUA Policy is issued in reliance upon the
truth of such representations and that my policy and my application therefore embody all agreements existing between
myself and the JUA or any of its brokers relating to this insurance.** _____ **Initial here**

Date _____

Signature of Applicant _____

Broker must sign this application -

I certify that I am duly licensed by an insurer authorized in South Carolina to write liability insurance other than automobile.

I certify that I have reviewed this application.

Date _____

Signature of Broker _____

*The information contained in this application is privileged and confidential. It is intended only for the use of the JUA. If the
reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this
application is strictly prohibited. If you have received this application in error, please notify us immediately by telephone and
return the original message to us via the U.S. Postal Service. Thank you.*