Physicians' Reciprocal Insurers

Healthcare Facility
DDS/DMD Application

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

1800 Northern Blvd
Roslyn, New York 11576
Telephone: (516) 365-6690 Fax: (516) 775-4224

HEALTHCARE FACILITY DDS/DMD APPLICATION

1. Name: ____

2. Name of Clinic/Center: ____

Address: ____

3. Dental School attended: ______________________________ Date of Graduation: ___________________

4. NYS License Number ________________________

5. Social Security Number _______________________

6. Date of Birth: ________________

7. How many hours per week do you work on behalf of the Clinic/Center? __________

8. Do you have admitting privileges at any area hospitals? Yes No If yes, please list in comments #21.

9. Do you admit clinic patients for inpatient treatment? Yes No

If yes, provide the number of annual admissions ______________

10. Do you wish coverage to extend to clinic patient admissions? Yes No

11. Please indicate your practice specialty below:

General Dentistry
Endodontics
Oral/Maxillofacial Surgery
Orthodontics
Pediatric Dentistry
Periodontics
Prosthodontics
Public Health
Anesthesiology (Dental) – Conscious Sedation
Anesthesiology (Dental) – General Anesthesia

12. Indicate which of the following procedures are performed by you:

TMJ – Phase II (irreversible treatments regarding bridgework, surgery, orthodontics undertaken primarily to treat a TMJ disorder).
Implant surgery
Extraction of impacted teeth
Sleep apnea therapy - o with referral from primary care physician o without referral from primary care physician
"Sargenti" or similar endodontic techniques
Implant restoration
Weight loss therapy* - o with referral from primary care physician o without referral from primary care physician
Molar Endodontic on permanent teeth

13. Have you **ever** had a malpractice claim or suit filed against you? Yes No
If Yes, explain details in Comments, #21.

14. Has any government agency **ever** investigated, revoked, suspended, restricted or taken any other action against either your narcotics license or your license to practice? Yes No If yes, explain details in Comments, #21.

15. Have you **ever** been convicted of a crime? Yes No If yes, explain details in Comments, #21.

16. Have you **ever** had any privileges at any hospital or institution reduced, revoked, restricted or suspended? Yes No
If yes, explain details in Comments, #21.

17. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? Yes No

If yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

18. Have you **ever** had professional liability insurance refused, declined, cancelled or accepted on special terms?

Yes No If yes, explain details in Comments, #2.

19. Name of your current malpractice insurer (if none, indicate "none"): ___________________________________
Limits of Liability: ________________ Effective Dates: ___________________ Policy #__________________

20. Does this Malpractice Policy cover you for acts at the Clinic/Center? Yes No

21. COMMENTS:

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AGREEMENT: I understand that this insurance will only cover me for my professional services performed at the addresses indicated on the declarations page of the Named Insured's policy.

NOTICE

Applicants considering claims-made coverage must take note of the following:

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

The policy covers claims actually made against the insured and incidents reported while the policy remains in effect and all coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases additional extended reporting period coverage which will provide coverage for an unlimited time period without any gap in coverage.

The rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage and such rate may be subject to substantial increase over the rates currently in effect. The average statewide percentage changes, and the effective dates, of each rate revision which PRI has implemented in this State during the five (5) year period immediately preceding the effective date of the policy will be provided upon the written request of the insured. Such past changes may or may not be indicative of future rate changes.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims-made or incidents reported after such period of sixty (60) days.

During the first few years of coverage on a claims-made basis, the annual rate is comparatively lower than occurrence rates, however, such annual rate increases significantly, independent of overall rate level increases, until the claims-made relationship reaches maturity.
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.

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Printed Name

_____________________________________ __________________
Physician's Signature Date