OMS NATIONAL INSURANCE COMPANY, RRG
NEW TO COMPANY PROFESSIONAL LIABILITY APPLICATION
omsnic.com
(800) 522-6670

OMSNIC
DEFENDING THE SPECIALTY

Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.
IL & NC Notice: This policy is issued by your risk retention group. Your risk retention group is not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.
WI Notice: Under the federal liability risk retention act of 1986 (15 USC 3901 to 3906) the Wisconsin insurance security fund is not available for payment of claims if this risk retention group becomes insolvent. In that event, you will be personally liable for payment of claims up to your limit of liability under s. 655.23 (4), Wis. Stat.

GENERAL INFORMATION

Full Name: _____ Suffix (i.e. DDS): _____

Cell Phone: _____ E-Mail: _____ Date of Birth: _____

COVERAGE INFORMATION

If Yes to any of the questions below, please provide additional information.

Requested Effective Date: _____ Coverage Type: **Claims-Made**

Requested Retroactive Date: _____

Requested Limits of Liability (per patient/total limit):

○ $1,000,000/$3,000,000	○ $3,000,000/$6,000,000	○ $100,000/$300,000 (LA only)	○ $1,300,000/$3,900,000 (NY only)
○ $2,000,000/$6,000,000	○ $5,000,000/$6,000,000	○ $500,000/$1,500,000 IN only)	○ Med Mal Cap Limit (VA only)

Note: All Limits of Liability are not available in all states.

Do you practice less than 20 hours per week/1,000 hours per year? ○ Yes ○ No

Have you ever practiced without professional liability insurance? ○ Yes ○ No

Has any insurer ever cancelled or non-renewed your professional liability insurance for any reason? ○ Yes ○ No

PRACTICE INFORMATION

If you practice at more than one location, please provide additional locations.

Practice Name: _____

Practice Address: _____
Street City State Zip

Mailing Address: _____ ☐ Same as practice
Street City State Zip

Billing Address: _____ ☐ Same as practice
Street City State Zip

Type of Location: ☐ OMS Office ☐ Hospital ☐ Surgi-Center ☐ Dental Office ☐ Other _____

Role at This Location: ☐ Sole Owner ☐ Partner/Member/Shareholder ☐ Employee ☐ Independent Contractor

Choose any market segment that represents more than 50% of your annual revenues:
☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other _____

Other than your current location(s), have you practiced at any other locations in the last 10 years? ☐ Yes ☐ No
If Yes, please provide the practice name, your affiliation, and address.

EDUCATION & LICENSE INFORMATION

If Yes to any of the questions below, please provide additional information.

Dental School: _____ Year of Graduation: _____
Medical School: _____ Year of Graduation: _____
OMS Residency: _____ Year of Graduation: _____

Please list all states where you have a dental and/or medical license: _____

Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory board? ○ Yes ○ No

Has your license to practice ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand? ○ Yes ○ No

PROCEDURES

Do you perform:

1. full body liposuction ○ Yes ○ No
2. minor medical and surgical procedures below the head and neck, that requires an active medical license ○ Yes ○ No
3. any of the below procedures not in conjunction with a maxillary reconstructive procedure:
   ☐ Blepharoplasty ☐ Rhytidectomy ☐ Otoplasty ☐ Hair Transplants ☐ Rhinoplasty

CLAIMS & EXPERIENCE INFORMATION

If Yes to any of the questions below, please provide additional information.

Have you:

1. had any malpractice claims made against you? ○ Yes ○ No
2. become aware of any incident(s) which might give rise to a claim being made against you? ○ Yes ○ No
3. ever been investigated for, or charged with fraud, including Medicaid or Medicare? ○ Yes ○ No
4. ever been convicted of a criminal offense other than a misdemeanor motor vehicle violation? ○ Yes ○ No
5. ever been a patient or a participant in any alcohol/chemical dependency or mental health rehabilitation program? ○ Yes ○ No
6. experienced or become aware of any illness or physical disability that impairs or could impair your ability to practice? ○ Yes ○ No
7. ever had your hospital privileges reduced, restricted, or suspended? ○ Yes ○ No

PRIVACY NOTICE

OMS National Insurance Company considers all transactions with us private and confidential. The United States Department of Health and Human Services has issued an opinion letter indicating that the obtaining and maintaining of professional liability insurance is part of health care operations and therefore would not require a business associate agreement or any releases for disclosure of Protected Health Information (PHI) under the Health Insurance Portability and Accountability ACT (HIPAA). We may use and disclose Protected Health Information in our possession for proper management, administration and/or to fulfill any present of future legal responsibilities provided that the disclosures are required by law; or that such uses are permitted under state and federal confidentiality laws; or that we have received assurances of the confidential handling of such Protected Health Information. We will require all subcontractors and agents that perform the services we are obligated to perform under this application to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to you and to us for any Protected Health Information that they receive, use or have access to. Should this application be declined or withdrawn, the protections of this statement will remain in force, and we shall make no further uses and disclosures of Protected Health Information, except for the proper management and administration of our business or as required by law.

PRIOR ACTS CERTIFICATION

If you request coverage for "Prior Acts" for your professional liability exposure, you must inform all prior insurance carriers of any incidents or circumstances that might reasonably result in a claim against you. Please provide written documentation which verifies that you have informed all prior insurance carriers of such incidents or circumstances. It is not the intent of the OMS National Insurance Company Policy to cover known patient injuries which occurred prior to the effective date of your OMS National Insurance Company Policy. Your prior insurance carriers are responsible for covering claims arising out of known patient injuries which occurred prior to the effective date of this policy. Please read and sign the following statement.

I certify that I am not aware of any incidents which I might reasonably expect to result in a claim, except those listed in this application for insurance. I understand that my OMS National Insurance Company Policy will not provide coverage for such incidents of which I am aware regardless of whether I have reported them to my prior insurance carriers.

Signature: _____ Date: _____

TELEPHONE CONSUMER PROTECTION ACT CONSENT

By providing a Cell Phone number, I agree to receive calls and/or texts to that number from the Company or its authorized representative, regarding my application for coverage of service regarding my coverage. I understand these calls may be generated using an automated technology. I understand consent is not required. I understand my consent is not a condition of purchase.

Virginia Cap Limit (VA Only)

I understand that if I elect to participate in the Virginia Cap Limit, my liability limits will increase annually as the recoverable amount increases.

Signature: _____ Date: _____

ACKNOWLEDGEMENT

I, The undersigned, hereby declare that all answers and statements herein given are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject of this application has been omitted or withheld. I understand that these answers and statements are material and as such will be relied upon in the determination by OMS National Insurance Company, Risk Retention Group, ("Company") in granting professional liability insurance coverage. I understand the documents provided with this application are made a part of any policy that is issued. Any concealment or misrepresentation of a material fact will render the insurance issued as a result of this application null and void. Further, it is recognized and agreed that as a prerequisite to acceptance of this application, in consideration for issuing professional liability insurance coverage to me, I agree to abide by any recommendation of the Company's Underwriting Committees. I authorize any state board of examiners or licensors, hospital board or committee, insurance company, professional society, past or present business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein, to release such information to the Company, its Underwriting Committees or its assigns. I authorize the use of a copy of this Acknowledgment in lieu of its original.

1. I understand that the professional liability insurance for which this application is made is claims-made coverage for an individual oral and maxillofacial surgeon. This claims-made policy covers claims arising from the practice of oral and maxillofacial surgery on or after the Retroactive Date shown in the Declarations, and reported to the Company during the policy period. This policy does not provide coverage for any claim first made and reported before the beginning of the policy period or after the end of the policy period.
2. I understand that the execution of this application is not a guarantee of coverage and that the Company may, in its sole and absolute discretion, accept or reject this application for professional liability insurance coverage.
3. I represent that I have received and carefully reviewed all the information contained in the most recent Information Circular including any supplements thereto and that I have not relied upon any representation or other information (whether oral or written) other than as set forth in the Information Circular and this application or answers furnished in writing by the Company.
4. I am aware that the Company is an Illinois Risk Retention Group which is not subject to all of the insurance laws and regulations of states other than Illinois, including those which provide for state insolvency guaranty funds. Further, I understand that to the extent that the Company may be deemed to be offering a security, the Company is relying on an exemption from registration under the Securities Act of 1933 and from the state Blue Sky Laws.
5. By providing your e-mail address you agree to receive electronic communication regarding your OMSGuard™ policy and other important company information.

This acknowledgement shall be governed and interpreted in accordance with the laws of the State of Illinois.

Any person who knowingly, and with intent to defraud or deceive 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 act, which is a crime and may subject such person to criminal and civil penalties.
NY - 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.

Signature: _____ Date: _____

Please use the space below to provide additional information requested: