PSIC | Professional Solutions INSURANCE COMPANY

Mobile Dentistry Supplement

A. APPLICANT INFORMATION

Dentist's Name: ____
First Middle Last

Name of Mobile Practice: ____

Mobile Office Phone: ____________________ Mobile Office Fax: ____________________

Cell Phone: ____________________ Email Address: ____________________
Your email address will never be sold. It will be used to send you important messages.

B. PRACTICE ACTIVITIES

1. Indicate the type of locations and percentages where the mobile dentistry practice provides services:
   - ❑ Schools ________ % ❑ Prisons ________ % ❑ Nursing Homes ________ %
   - ❑ Other ________ % (please explain): ______________________________
2. List all counties and states this mobile dentistry practice will provide services to: ______________________________
   ____
   ____
3. What percentage of your total practice time do you practice in a mobile dentistry setting? ____________%
4. Are protocols in place to distribute a standardized information sheet for the patient/guardian which includes contact information; name of dental providers (dentists/staff); description of services rendered; and, a referral/follow up plan? .... ❑ Yes ❑ No
   If yes, please send a copy of the protocol.
5. Is medical clearance obtained for all dental procedures? .... ❑ Yes ❑ No
6. Are procedures limited to prophylaxis and exams? .... ❑ Yes ❑ No
   If no, what procedures will you perform? ______________________________
   If no, what percentage are restorative: ________ % What percentage are preventative: ________ % (Should total 100%)
7. Do you obtain an informed consent form? .... ❑ Yes ❑ No
   If yes, please provide a copy.
8. For emergency procedures, do you have a written protocol for follow-up care? .... ❑ Yes ❑ No
   If yes, please send a copy of the protocol.
9. Does this facility meet the physical requirements set forth by the state dental board? .... ❑ Yes ❑ No

IF YOU ANSWERED "NO" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A SEPARATE PIECE OF PAPER.

C. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

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.

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C. SIGNATURE REQUIRED (continued)

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.

______________________________	______________________________
Signature of Applicant	Date
______________________________	______________________________
Signature of Soliciting Agent (Please Print Full Name)	Agency Name

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

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

Email: dentalsubmissions@psicinsurance.com

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