Mikel's Insurance Services
P.O. Box 997 Downey, CA 90241
(800) 928-0431 fax (562) 928-8149
Over 25 years of Service

~ MedPro Dental Malpractice Insurance ~

Application Instructions

"Policy Change Dental"

Dear Doctor,

Please read the questions carefully and fill out the application as completely as possible.

From: Dr.____ Date: _____________

Fax to: **562-928-8149**
Attn: **Richard Walton – Mikel's Insurance Services**

Email scanned applications to: **rwalton@mikels-ins.com**

To mail application send to: **P.O. Box 997, Downey, CA 90241-0997**

Additional Application Processing Choices - (circle)

Option 1: If you would like to complete an **On-line application** on MedPro's website, please email your request to rwalton@mikels-ins.com or call the office for more information.

Option 2: If you would like our agency to enter your paper application information on your behalf on-line for your final review & E-Signature process. (Email address needed)

Are you a Punjabi Dental Society member? **Yes / No***

*If you are not a member and interested in more benefit information check here_____

Please don't hesitate to call if you have any questions.

Respectfully,
Richard M. Walton
Commercial Group - Dental
Office (800) 928-0431 Ext. 128

www.**MedPro**Dentist.com

DENTAL POLICY CHANGE REQUEST

I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Requested Effective Date of Change: (MM/DD/YYYY) ______________________ 12:01 a.m.

B. General Information:

Last Name ______________________ First Name ______________________ M.I. ____ Suffix ________

Date of Birth (MM/DD/YYYY) ______________________ Social Security Number (Optional) ______________________

National Provider Identifier (NPI) ______________________

E-Mail ______________________

Business Fax ______________ Business Phone ______________ Residence/Cell Phone ______________

C. Practice Location(s):
(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice ____________ Type of Location: ☐ Hospital ☐ Office ☐ Residence

Location Name ______________________

Number and Street ______________________ Suite ____________

City ______________ State ____________ County ____________ Zip Code ____________

2. Additional Location:

% of Practice ____________ Type of Location: ☐ Hospital ☐ Office ☐ Residence

Location Name ______________________

Number and Street ______________________ Suite ____________

City ______________ State ____________ County ____________ Zip Code ____________

D. Preferred Billing and Correspondence Address:

☐ Location Number (From Section C. above) ____________ ☐ Other (please enter below)

Number and Street ______________________ Suite ____________

City ______________________ State ________ Zip Code ____________

II. PRACTICE INFORMATION

A. States in which you hold a license to practice dentistry:
Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

	State	License #	Active	Inactive	Temporary	Pending
1.	________	______________	☐	☐	☐	☐
2.	________	______________	☐	☐	☐	☐

3. DEA License? ☐ Yes ☐ No

III. RATING INFORMATION

A. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage: (If none, please enter '0' in the space provided.)

Patients Per Week ________ Hours Per Week ______ Unscheduled New Walk-In Patients Per Week ________

B. Please check your present specialty:

☐ General Dentist
☐ Orthodontist
☐ Pediatric Dentist
☐ Endodontist
☐ Periodontist
☐ Prosthodontist
☐ Oral Pathologist
☐ Dental Anesthesiologist
☐ Pain Management (Please explain) ________________
☐ Other (Please explain) ________________
☐ Oral & Maxillofacial Surgeon
 ☐ Dual Degree
 ☐ Board Certified
 Date of Certification (MM/YYYY) ________

C. Please check procedures you will perform in your practice:

☐ **Orthodontic Full Mouth Banding**
 Year you began this procedure (YYYY) ________________
☐ **Placement of Mini Implants for Orthodontic/Prosthesis**
☐ **Implant Prosthesis/Supported Prosthesis**
☐ **Sargenti Root Canal Method Utilizing N2 or Similar Paste**
☐ **Surgical Placement of Implant Fixtures**
 Year you began this procedure (YYYY) ________________
☐ **Botox, Dermal Fillers (i.e. Injections)**
☐ **Cosmetic Full Mouth Rehabilitation**
☐ **Alternative (Holistic) Dentistry/Medicine**
 Please explain ________________
☐ **Sleep Apnea Therapy**
 Do you treat only after a physician referral? ☐ Yes ☐ No
☐ **Obesity/Weight Control Treatment**

Third Molar Extractions (CPT/CDT Codes)

☐ **Erupted (D7110, D7120, D7210)**
 Year you began this procedure (YYYY) ________________
☐ **Partially Impacted (D7220, D7230)**
 Year you began this procedure (YYYY) ________________
☐ **Fully Impacted (D7240, D7241, D7250)**
 Year you began this procedure (YYYY) ________________

☐ **Sinus Lifts**
☐ **Palatal Inserts**
 Do you treat only after a physician referral? ☐ Yes ☐ No
☐ **Nerve Grafts**
☐ **Cleft Lip and Palate Surgery**
☐ **Face Lifts**
☐ **Management of Malignant Lesions**
☐ **Orthognathic Surgery**
☐ **Rhinoplasty**
☐ **Skin Peels**
☐ **Spa Services**
 Please explain ________________
☐ **TMJ Surgery**
 ☐ **Arthroscopy**
 ☐ **Implant**
 ☐ **Reconstruction**
☐ **Trigger Point Injections**
☐ **Other**
 Please explain ________________

D. Indicate the percentage of your practice devoted to the following procedures:
(Total does not have to equal 100%)

_____ % Denture Procedures ☐ Same Day or Economy ☐ Replacement ☐ Relines

_____ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)

_____ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)

_____ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)

_____ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

III. RATING INFORMATION (CONTINUED)

E. Please indicate which procedures you perform and whether you obtain informed consent and training for each of the procedures selected.

Procedure	Informed Consent Type			Training		
☐ Orthodontic Full Mouth Banding	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Surgical Placement of Implant Fixtures	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Partially Impacted Third Molar Extractions	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Fully Impacted Third Molar Extractions	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Nitrous Oxide Analgesia	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Conscious Sedation	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ General Anesthesia/Unconscious Sedation	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Facial Surgery	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Botox, Dermal Fillers (i.e. Injections)	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None
☐ Other (Please explain) ____________	☐ Written	☐ Oral	☐ None	☐ CE	☐ Post Grad	☐ None

F. Have you discontinued any procedures listed in C. or D. above? ☐ Yes ☐ No

Which procedures? ______________________________ When? (MM/DD/YYYY) ____________________

G. Do you treat non-federal prison inmates? ☐ Yes ☐ No

If yes, what percentage of your practice is devoted to treating non-federal inmates? ____________ %

H. Do you treat or review treatment of federal prison inmates? ☐ Yes ☐ No

If yes, please explain ____

IV. PRACTICE ORGANIZATION INFORMATION

Please check boxes that best describe your practice affiliation(s).

A. Employment Status:

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed (MM/DD/YYYY) ____________

B. Entity / Organization Type: (You must check at least one box.)

- ☐ Solo Unincorporated/Sole Proprietor
- ☐ Solo Incorporated
- ☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company
- ☐ State Licensed Dental Surgery Center
- ☐ Clinic Receives Governmental Immunity
- ☐ Other (Please explain) ________________
- ☐ Mobile or Portable Dental Practice
- ☐ Nursing Home Based Practice
- ☐ Dental School - Faculty
  - ☐ Clinical supervision of students
  - Hours per week ____________
- ☐ Dental Students/Residents

C. Name all of your affiliated professional corporations or associations (including DBA's and Individual Dentists):

____

D. Is this entity or employer currently insured with The Medical Protective Company?

If yes, please provide The Medical Protective Company individual, corporation or partnership policy and group number, if known.

Policy # ____________________ Group # ____________________ ☐ Yes ☐ No

E. Do you desire coverage for this entity? ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

☐ **Shared Limit -** Your individual policy limits will be shared with your **Solo Corporation**. This option is **only** available if you are Solo Incorporated and you have no employed or contracted Dentists.

☐ **Separate Limit -** Available for all Entity/Organization Types. A separate entity application is required.

To request separate entity coverage, please contact your agent or Med Pro customer service (800-4MedPro) to complete an entity application for consideration.

V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

☐ *Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242* - (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

☐ IM/IV ☐ Oral

☐ *General Anesthesia Utilizing CPT/CDT Code D09220-* (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.

B. ☐ **Please "X" here if this section *does not* apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.**

VI. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? ☐ Yes ☐ No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here ______

Name ______________________________

Number and Street ______________________________ Suite ______________

City ______________________ State __________ Zip __________ Phone Number ______________

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

VII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments"**) for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature ______________________________ Date Signed ______________

Type or Print Name ______________________________

VIII. ADDITIONAL INFORMATION

Attach a separate piece of paper if additional space is needed.