OMSNIC
DEFENDING THE SPECIALTY

OMS NATIONAL INSURANCE COMPANY, RRG

FOLLOW UP APPLICATION

SECOND YEAR NEW-TO-PRACTICE PROFESSIONAL LIABILITY APPLICATION

A **CHECKLIST** has been provided for your convenience. Please review and attach all pertinent information. Answers must be typed or printed in ink. Please answer all questions completely. You must sign and date the application. Signature stamps or signature of office personnel are not acceptable. Also, please review the **IMPORTANT FACTS** information following the checklist.

1. Name: ____

2. Primary Practice Location: ____
____

   County: ____________________ Percentage of Time: ____________

3. Office Phone Number: ____________________ Office Fax Number: ____________________

4. Mailing Address: ____
(If different from above) ____

5. Additional office locations:

   2) ____
   ____
   County: ____________________ Percentage of Time: ____________
   How long at this practice location? From: ____________ To: ____________

   3) ____
   ____
   County: ____________________ Percentage of Time: ____________
   From: ____________ To: ____________

   4) ____
   ____
   County: ____________________ Percentage of Time: ____________
   How long at this practice location? From: ____________ To: ____________

   For additional office locations, please indicate on a separate sheet of paper.

6. When was the last OMSNIC Risk Management seminar you attended?
   Location: ____________________ Date: ____________________

7. Total number of hours per average week devoted in your practice to:
   (Residents and New-to-Practice Doctors: Please answer all questions based on your anticipated future practice.)

   A. Actual patient care ________
   B. Actual patient record-keeping ________
   C. Consulting ________
   D. Night telephone calling your surgical patients for that day ________
   E. Hospital rounds ________
   F. Administrative duties for the office ________
   G. OMS residency training ________

8. Are you ABOMS certified? ☐ Yes ☐ No

If yes, date of certification ____________________________________

If, not, are you ABOMS eligible? ☐ Yes ☐ No

If yes, date of certification ____________________________________

9. Current hospital appointments:

Name of Hospital	City	State

Attach a sample of all informed consent forms used in your practice.

10. On a weekly average, how many surgical procedures do you perform?

In your office: ______________________________________ In the hospital: ______________________________________

Residents and New-to-Practice Doctors: Please answer all questions based on your anticipated future practice.

11. What percent of your office procedures are done under the following (total must equal 100%).

General Anesthesia: _______________% IV Sedation _______________% Local Anesthesia Only _______________%

Residents and New-To-Practice Doctors: Please answer all questions based on your anticipated future practice.

12. Please mark the equipment you use for any IV sedation and general anesthesia cases.

Pulse Oximeter _____________ Capnography _____________

Blood Pressure Cuff _____________ EKG _____________

13. Approximately how many of the following procedures did you perform in the past 12 months? If none, indicate "0".

Residents and New-to-Practice Doctors: Please answer all questions based on your anticipated future practice..

A.	Extractions-teeth	__________	I.	Facial fractures	__________
B.	General anesthesia/deep sedation	__________	J.	Major reconstructive bone grafts	__________
C.	Conscious sedation	__________	K.	Nerve exploration /grafting	__________
D.	Dental implants (not patients)	__________	L.	Benign lesions definitively treated	__________
E.	Sinus elevation grafting	__________	M.	Malignant lesions definitively treated	__________
F.	Orthognathic maxillary osteotomy	__________	N.	Laser skin resurfacing patients	__________
	Mandibular osteotomy	__________	*O.	Rhinoplasty	__________
	Distraction osteogenesis	__________	*P.	Blepharoplasty	__________
G.	Temporomandibular joint-Open joint	__________	*Q.	Rhytidectomy	__________
	Arthroscopy	__________	*R.	Otoplasty	__________
	Arthrocentesis	__________	*S.	Hair transplant patients	__________
H.	Total or partial prosthetic joint replacements	__________	**T.	Nonfacial liposuction patients	__________

Coverage is automatically afforded for the performance of **rhinoplasty** only when performed in conjunction with a maxillary reconstructive surgical procedure.

***If you are requesting coverage for the performance of blepharoplasty, rhytidectomy, otoplasty, hair transplants** for any reason or **rhinoplasty not** performed in conjunction with a maxillary reconstructive surgical procedure, at least two of the following three items must be provided.

1. Credentials from a local hospital listing privileges for these procedures.
2. Proof of training (i.e., letter from residency director, fellowship director or preceptor that states you have been "trained to competence" in each procedure requiring coverage).
3. Operative reports for **EACH** procedure:
   A. Five (5) cases in which you were the primary surgeons.
   B. Ten (10) cases in which you were the assistant surgeon.

****Please call OMSNIC regarding these procedures.

14. Please list below the number of support staff in the following categories employed by you, your partnership, corporation, etc.

Nurses	___________	X-Ray Technicians	___________	CRNA'S	___________
Surgical Assistants	___________	Dental Assistants	___________	Secretarial/Clerical	___________

Signature: ____ Date: ________________________

CHECK LIST

DID YOU ?

1. **READ THE HIPAA NOTICE**

2. Sign the Application

- ☐ Page 8, for acknowledgement of application; and
- ☐ Each incident/claims form, if applicable.

3. **INCLUDE:**

- ☐ Samples of all your medical history and informed consent forms;
- ☐ A copy of your approved hospital privilege delineation for each hospital at which you currently have privileges;
- ☐ Cosmetic surgery documentation (if applicable);
- ☐ Incident/Claims form (if applicable);
- ☐ A copy of your yellow page ads and copies of any printed advertising you do;
- ☐ A blank sheet of your office letterhead;
- ☐ A certificate of insurance for your independent contractors (if applicable); and
- ☐ Any additional information pertinent to your application.
- ☐ If you are an owner, officer, partner, administrator or employee of any other professional, medical or dental organization, please provide the name of the organization, your status with the organization and the city and state of its location.

4. **FOR PART-TIME COVERAGE**

- ☐ If you are a full-time student, attach a letter from the registrar which verifies enrollment;
- ☐ If you are a full-time academician, attach documentation from the institution verifying your full-time status and coverage;
- ☐ If you are disabled, attach medical documentation from your attending physician regarding your disability;
- ☐ If you are full-time military or government services oral and maxillofacial surgeon, please provide an explanation with respect to your private practice setting on an additional sheet of paper.

(TURN THE PAGE FOR IMPORTANT FACTS ABOUT OMSNIC)

OMSNIC Important Facts

Did You Know?

Program Features

OMSNIC's Website is dds4dds.com
Communicate with our live assistant on-line. Click the gray box in the right hand corner and send your email.

HIPAA Compliance Program
You can locate HIPAA forms and take the HIPAA on-line training course on our website.

Risk Management
A risk management course is available on-line at dds4dds.com. You can receive a 5% premium credit for two years by taking and passing the on-line course. In person risk management seminars are also available, check the website for upcoming seminar information. Courses must be completed within 60 days of the policy effective date to apply the credit to the current policy.

Monitor
The *Monitor* is OMSNIC's risk management newsletter that addresses the current oral and maxillofacial issues, provides insight to litigation and provides staff information to address office issues. Back issues of the *Monitor* are also available on our website.

Policy Features

Contractual Liability
We will not pay or defend against any liability you have assumed under any contract or agreement unless such liability is otherwise covered by our Policy, and:

You would have been liable for damages without regard to the contract or agreement; **OR** You have assumed liability for damages under a contract or agreement with (a) a Health Maintenance Organization; (b) a Preferred Provider Organization; (c) Independent Practice Organization; or (d) a similar managed care or health care provider organization.

If you have entered into a written or oral agreement with another party, it is strongly recommended that you consult with your personal attorney to determine if there are any deficiencies which may subsequently impact your professional liability insurance coverage.

Coverage Outside the United States
The OMSNIC policy provides coverage for oral surgery procedures performed outside the United States when the claim is brought in the United States for a maximum of 30 days in a calendar year.

Employee Practice Liability
Defense coverage is afforded to protected organizations for an employment practices proceeding, i.e., investigation, civil action, demand for arbitration or administrative proceeding, by a present or former employee. The maximum limits per policy period are $25,000 for each covered proceeding/$75,000 annual total for all covered proceedings.

General Anesthesia and IV Sedation
Coverage is afforded for the administration of general anesthesia and I.V. sedation as follows:

Regardless of the practice location or type of patient, your are covered for the administration of general anesthesia and I.V. sedation provided: (1) it is for a dental or oral and maxillofacial procedure; (2) properly trained personnel and appropriate equipment are utilized; and (3) it is permitted in your state under the dental practices acts and/or other applicable state law.

Oral and Maxillofacial Surgery
Oral and maxillofacial surgery means the specialty of surgery which includes the diagnosis, surgical and adjunctive treatment of diseases and defects involving both the functional and aesthetic aspects of the hard and soft tissues or the oral and maxillofacial region.

Organization Coverage
A separate policy is issued for all corporations (solo or multi-insured), partnership, and business entities or to those protected surgeons who practice under a D/B/A. There is no charge for this coverage. This policy protects against covered claims for bodily injury arising out of care provided by protected employees in support of oral and maxillofacial surgery care provided by oral and maxillofacial surgeons who are shareholders and who are insured under individual policies issued by us.

Peer Review
The OMSNIC policy affords coverage for your service on a review board or committee for AAOMS or one of its constituent professional societies that is responsible for evaluating the professional qualifications or performance of other oral surgeons.

Utilization Review
OMSNIC will not pay or defend against any liability for your failure or your refusal to authorize any care or payment for such care in providing utilization review for or on behalf of any managed care organization.