



**OMS NATIONAL INSURANCE COMPANY, RRG  
NEW BUSINESS PROFESSIONAL LIABILITY  
APPLICATION**

For Oral and Maxillofacial Surgeons

In order to expedite the application process, please be sure to answer all questions completely. Please be sure to include all additional documentation as requested in the application and sign and date the application.



# OMS NATIONAL INSURANCE COMPANY, RRG NEW BUSINESS PROFESSIONAL LIABILITY APPLICATION

Proposed Effective Date: \_\_\_\_\_

**Notice:** This Policy is issued by your risk retention group, which is not subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty fund protection is not available for your risk retention group.

Proposed Retroactive Date: \_\_\_\_\_

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. Use additional sheets of paper as needed. 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.

### General Information

1. Name: \_\_\_\_\_

2. Primary Practice Location: \_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

E-mail Address \_\_\_\_\_  
OMSNIC will only use your e-mail for important communications

3. Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

4. Mailing Address: \_\_\_\_\_  
(If different from primary) \_\_\_\_\_

5. **Additional office locations:**  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

**Additional office locations:**  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

**Additional office locations:**  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_ Percentage of Time: \_\_\_\_\_

How long at this practice location? From: \_\_\_\_\_ To: \_\_\_\_\_

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

**General Information (Continued)**

6. How is your practice organized? (Mark One)

- |  |   |
|--|---|
| <input type="checkbox"/> Self-Employed Solo Practice         | <input type="checkbox"/> Group Professional Corporation           |
| <input type="checkbox"/> Individual Professional Corporation | <input type="checkbox"/> Employed by Another Individual or Entity |
| <input type="checkbox"/> Partnership                         | <input type="checkbox"/> Independent Contractor                   |

7. If you practice as part of a corporation, partnership, group, trade name or DBA, please provide the entity name and its retroactive date:  
(See the Check List on page 11 of this application for additional information regarding Organization coverage)

\_\_\_\_\_

8. Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

9. When was the last Risk Management seminar you attended?

Host/Location: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach a certificate of completion if a non-OMSNIC seminar was attended within the last year.

**Coverage Information**

Limits of Coverage

NOTE: All Limits of Coverage are not available in all states

**Indiana – Limits of \$250,000 per patient/\$750,000 total limit**

**Louisiana – Limits of \$100,000 per patient/\$300,000 total limit**

10. Please mark the Limits of Coverage you desire:

- |  |  |
|--|--|
| <input type="checkbox"/> \$1,000,000 per patient/\$3,000,000 total limit | <input type="checkbox"/> \$1,300,000 per patient/\$3,900,000 total limit (New York only) |
| <input type="checkbox"/> \$2,000,000 per patient/\$6,000,000 total limit | <input type="checkbox"/> \$3,000,000 per patient/\$6,000,000 total limit                 |
| <input type="checkbox"/> \$5,000,000 per patient/\$6,000,000 total limit |  |

11. Please list all of your previous professional liability insurers for the past 10 years:

<u>Insurance Company</u>	<u>From (Month/Year)</u>	<u>To (Month/Year)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please submit a copy of your current professional liability declarations page along with a 10-year loss run for each insurer listed above.

**Education & Licensure Information**

12.	Name of Institution	Degree	From (Month/Year)	To (Month/Year)
Dental School:	_____	_____	_____	_____
Medical School:	_____	_____	_____	_____
Internship:	_____	_____	_____	_____
OMS Residency:	_____	_____	_____	_____
Other Residency/Graduate School:	_____	_____	_____	_____
Other Specialty:	_____	_____	_____	_____

13. If you trained in a specialty other than oral and maxillofacial surgery, do you anticipate performing procedures related to that specialty in your practice?  Yes  No

**Education & Licensure Information (Continued)**

14. A. Please provide the following active and inactive licensure information:

Dental		Medical	
State	License Number	State	License Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Please provide your DEA license number: \_\_\_\_\_

C. Does your state have a specialty certification for oral and maxillofacial surgery?  Yes  No

If yes, please provide your license number: \_\_\_\_\_

15. Are you or is your office certified for general anesthesia by a state organization?  Yes  No

If yes, please provide permit number: \_\_\_\_\_ Date of issuance: \_\_\_\_\_

**Practice Information**

16. Total number of hours per average week devoted in your practice. If none, enter "0".

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

- |  |       |   |       |
|--|-------|---|-------|
| A. Actual patient care   | _____ | E. Hospital rounds                      | _____ |
| B. Actual patient record-keeping                                 | _____ | F. Administrative duties for the office | _____ |
| C. Consulting  | _____ | G. OMS residency training               | _____ |
| D. Night follow-up calls for your surgical patients for that day | _____ |   |       |

17. Are you involved in teaching, training or supervising any residents, students or fellows?  Yes  No

If yes, please complete the following:

a. Name of institution: \_\_\_\_\_

b. Does the institution provide professional liability coverage for this activity?  Yes  No

18. A. Have you read and do you understand the state dental practice act for each state in which you practice?  Yes  No

B. Are the services you render within the scope of those state dental practice acts?  Yes  No

C. Are you and your office HIPAA compliant?  Yes  No

19. A. Are you ABOMS certified?  Yes  No

If yes, date of certification or recertification \_\_\_\_\_

B. If not, are you currently in the certification process?  Yes  No

20. Have you renewed your AAOMS membership in the past 12 months?  Yes  No

**Note:** Coverage is only available to members in good standing with the American Association of Oral and Maxillofacial Surgeons.

**Practice Information (Continued)**

21. List all professional associates in your practice. (If any partner, shareholder, employee or independent contractor is not insured by OMSNIC, please provide the name of his/her professional liability insurer and evidence of insurance.)

Name of Associate	Position/Affiliation with the Practice	Present Insurer
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

22. Other than your current locations, please list all locations where you have practiced in the last 10 years. Include military service, if applicable.

Name of Practice	Address	From (Month/Year)	To (Month/Year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

23. Please indicate all practice location types for which you are requesting coverage:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> OMS Office        | <input type="checkbox"/> Nursing Home                  | <input type="checkbox"/> Mobile Dental Unit |
| <input type="checkbox"/> Dental Office     | <input type="checkbox"/> Hospital                      | <input type="checkbox"/> Imaging Facility   |
| <input type="checkbox"/> Government Office | <input type="checkbox"/> Dental Laboratory             | <input type="checkbox"/> Medi-Spa           |
| <input type="checkbox"/> Surgi-Center      | <input type="checkbox"/> Other (Please describe) _____ |   |

24. Current hospital appointments:

Name of Hospital	City	State
_____	_____	_____
_____	_____	_____
_____	_____	_____

25. What percent of your office procedures are done under the following (total must equal 100%)?  
(Residents and New-To-Practice Doctors: Please answer all questions based on your anticipated future practice.)

- |  |                               |
|--|-------------------------------|
| General Anesthesia/Deep Sedation: _____% | Nitrous Oxide: _____%         |
| IV/IM - Moderate Sedation: _____%        | Local Anesthesia Only: _____% |
| PO/Enteral Minimal Sedation: _____%      |                               |

26. Please mark the equipment you use for any sedation and anesthesia cases.

- |                           |                   |
|---------------------------|-------------------|
| Pulse Oximeter _____      | Capnography _____ |
| Blood Pressure Cuff _____ | EKG _____         |

27. Do you obtain written and signed informed consent from your patients prior to performing all oral and maxillofacial surgery procedures (including dentoalveolar)?

Yes  No

**Please attach a sample of all informed consent forms used in your practice.**

**Practice Information (Continued)**

28. Do you obtain medical history for all patients?  Yes  No

**Please attach a sample of the form used.**

*Please be advised that it may be contrary to state or local law to ask questions pertaining to AIDS/HIV or the use of illegal drugs on your medical history form. (We strongly recommend that you review your medical history form with a local attorney.)*

29. 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.)

30. A. Do you have CT Imaging equipment in your oral and maxillofacial surgery practice?  Yes  No

B. If yes, do you provide CT Imaging services on patients other than your own?  Yes  No

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

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

**Additional information is required if coverage is desired for the following procedures: blepharoplasty, rhytidectomy, otoplasty, hair transplants or rhinoplasty not performed in conjunction with a maxillary reconstructive procedure. Please refer to the Check List on Page 11.**

- |   |   |
|---|---|
| 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 _____<br><small>(Number of Implants, not patients)</small> | L. Benign lesions definitively treated _____    |
| E. Sinus elevation grafting _____   | M. Malignant lesions definitively treated _____ |
| F. Orthognathic maxillary osteotomy _____                                     | N. Laser skin resurfacing _____                 |
| Mandibular osteotomy _____  | O. Non-facial liposuction _____                 |
| Distraction osteogenesis _____  | P. Blepharoplasty _____                         |
| G. Temporomandibular joint-Open joint _____                                   | Q. Rhytidectomy _____                           |
| Arthroscopy _____   | R. Otoplasty _____                              |
| Arthrocentesis _____  | S. Hair transplant _____                        |
| H. Total or partial prosthetic joint _____                                    | *T. Rhinoplasty _____                           |
| replacements _____  |   |

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

32. Do you perform any other procedures outside the head and neck region?  Yes  No

If yes, please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- |                           |                               |
|---------------------------|-------------------------------|
| Nurses _____              | X-Ray Technicians _____       |
| Surgical Assistants _____ | Dental Assistants _____       |
| Aestheticians _____       | Secretarial/Clerical _____    |
| CRNA's _____              | Other (Please describe) _____ |

## Claims & Experience Information

Please provide additional detailed information for all "Yes" answers to the following questions on a separate sheet of paper.

34. Have you ever been denied a dental/medical license or the right to take the examination by any state, territory or district?  Yes  No
35. Has any government agency, state board or committee ever suspended, revoked or taken any other action (including probation) against either your narcotics license or your license to practice dentistry/medicine or is either license under investigation in any state?  Yes  No
36. Have you ever been convicted of a criminal offense other than misdemeanor motor vehicle violation?  Yes  No
37. Have you ever been a patient or a participant in any alcohol/chemical dependency or mental health rehabilitation program?  Yes  No
38. Have you experienced or become aware of any illness or physical disability that impairs or could impair your ability to practice oral and maxillofacial surgery?  Yes  No  
**If yes, please include documentation from your treating physician stating your condition, prognosis and any limitations on your ability to practice oral and maxillofacial surgery**
39. Has any insurer ever cancelled, declined or modified coverage (i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused to renew any professional liability insurance policy or any similar insurance?  Yes  No
40. Have you ever had your membership in a professional society suspended, revoked or refused?  Yes  No
41. Have you ever had your hospital privileges reduced, restricted or suspended?  Yes  No
42. Within the past 10 years, have you been sued or have any claims been made against you?  Yes  No  
If yes, have these claims been reported to any prior/current carrier?  Yes  No  
**Please complete an incident/claims form for each claim (copy attached).**
43. Do you have any knowledge of any incident which might give rise to a claim being made against you?  Yes  No  
If yes, has this claim been reported to any prior/current carrier?  Yes  No  
**Please complete an incident/claims form for each claim (copy attached).**
44. Have you ever been involved in a situation involving the death of a patient?  Yes  No  
If yes, has an incident report or claim been reported to any prior/current carrier?  Yes  No  
**Please complete an incident/claims form for each claim (copy attached).**

Incident/Claim/Investigation Form

Please complete a form for each claim/incident/investigation that you have been involved in. Please make photocopies of this form prior to completion if additional copies are needed.

Patient's Name and Age: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Date Suit Filed: \_\_\_\_\_

Allegations: \_\_\_\_\_

Written Informed Consent Used?  Yes  No

Present Status: (Check One)

- No claim yet made
- Claim made, suit not yet filed
- Suit pending
- Claim closed\*

\*If the claim has been closed, please state the date, method of closing and the amount paid (if any):

- Suit dismissed  
Date \_\_\_\_\_
- Suit settled - \$ \_\_\_\_\_  
Date \_\_\_\_\_
- Judgment - \$ \_\_\_\_\_  
Date \_\_\_\_\_

Description of Incident:

Please provide a detailed narrative. Include the following in your description along with any other information you feel would be pertinent: (Please attach additional sheets if necessary.)

- ➔ Your relationship to the case (i.e. primary treater)
- ➔ Exam findings and initial diagnosis
- ➔ Treatment involved
- ➔ Result of treatment and the condition of the patient
- ➔ Patient's subsequent course of treatment
- ➔ If settled, please indicate the reason for settlement

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY WARRANT AND REPRESENT THAT the above information is complete and true to the best of my knowledge and belief, and understand that, prior to my retroactive date, there is no coverage for any listed claim or incident provided by the OMS National Insurance Company Policy. I understand that this Incident/Claims Form and the answers and statements provided in this Incident/Claims Form are made a part of any policy that is issued.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 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 or 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: \_\_\_\_\_

## 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 exception from registration under the Securities Act of 1933 and from the state Blue Sky Laws.

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

Kentucky only – Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a 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.

New York only – Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a 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 (\$5,000) and the stated value of the claim for each violation.

Rhode Island only – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Check List

### Did You ?

1. **READ THE PRIVACY NOTICE**
2. **SIGN THE FOLLOWING:**
  - Page 9, for retroactive coverage (if prior acts coverage is requested)
  - Page 10, for acknowledgement of application
  - Each Incident/Claim/Investigation form
3. **INCLUDE:**
  - Samples of all your medical history and informed consent forms
  - Cosmetic surgery documentation (if applicable)

\*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 for each procedure

    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 surgeon
      - B. Ten (10) cases in which you were the assistant surgeon
  - Incident/Claim/Investigation forms (if applicable)
  - A copy of your current professional liability policy declarations page (if applicable)
  - A copy of your arbitration agreement (if applicable)
  - A copy of your yellow page ad(s) and copies of any printed advertising
  - A blank sheet of your office letterhead
  - A certificate of insurance for any independent contractors working for you (if applicable)
  - Any additional information pertinent to your application
4. **For Part-Time Coverage Requests:**
  - 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
5. **ORGANIZATION COVERAGE**
  - Attach a copy of the Articles of Incorporation indicating the date of incorporation
  - If you are an owner, officer, partner, administrator, employee or if you practice as part 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

(TURN THE PAGE FOR IMPORTANT FACTS ABOUT OMSNIC)

## OMSNIC Important Facts

### DID YOU KNOW?

#### PROGRAM FEATURES

##### OMSNIC'S WEBSITE IS [www.dds4dds.com](http://www.dds4dds.com)

You can obtain sample Informed Consent and Medical History Forms from our website. .

##### 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](http://dds4dds.com). You will be eligible to receive a 5% premium credit for three years by taking and passing the on-line course. Live, 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 year.

##### 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. You will receive the *Monitor* via email by providing your e-mail address in question 2. 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 and maxillofacial surgery procedures performed outside the United States for a maximum of 30 days in a calendar year when the claim is brought in the United States. The insured's primary practice must be located in the United States.

##### EMPLOYMENT PRACTICES 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, you 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; (3) it is permitted in your state under the dental practices acts and/or other applicable state law; and (4) you are certified.

##### 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 of 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 unpaid 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. This also includes coverage for your paid service on a board or committee sponsored by us for the purpose of assisting our business functions.

##### 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.