

DENTAL POLICY CHANGE REQUEST

Policy # _____

Please Fax or E-Mail Application: 888-284-4618 / RRGdental@medpro.com
If you have questions, please contact your agent or call 1-800-4-MedPro

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 Question 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.

- | | Active | Inactive | Temporary | Pending |
|--------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State _____ License # _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State _____ License # _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

III. RATING INFORMATION

A. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require MedPro RRG Risk Retention Group 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:

- | | | |
|--------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> General Dentist | <input type="checkbox"/> Prosthodontist | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Oral Pathologist | <input type="checkbox"/> Dual Degree |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist | <input type="checkbox"/> Board Certified |
| <input type="checkbox"/> Endodontist | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____ |
| <input type="checkbox"/> Periodontist | <input type="checkbox"/> Other (Please explain) _____ | |

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

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><input type="checkbox"/> Orthodontic Full Mouth Banding
Year you began this procedure (YYYY) _____</p> <p><input type="checkbox"/> Placement of Mini Implants for Orthodontic/Prosthesis</p> <p><input type="checkbox"/> Implant Prosthesis/Supported Prosthesis</p> <p><input type="checkbox"/> Sargenti Root Canal Method Utilizing N2 or Similar Paste</p> <p><input type="checkbox"/> Surgical Placement of Implant Fixtures
Year you began this procedure (YYYY) _____</p> <p><input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)</p> <p><input type="checkbox"/> Cosmetic Full Mouth Rehabilitation</p> <p><input type="checkbox"/> Alternative (Holistic) Dentistry/Medicine
Please explain _____</p> <p><input type="checkbox"/> Sleep Apnea Therapy
Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Obesity/Weight Control Treatment</p> <p><u>Third Molar Extractions (CPT/CDT Codes)</u></p> <p><input type="checkbox"/> Erupted (D7110, D7120, D7210)
Year you began this procedure (YYYY) _____</p> <p><input type="checkbox"/> Partially Impacted (D7220, D7230)
Year you began this procedure (YYYY) _____</p> <p><input type="checkbox"/> Fully Impacted (D7240, D7241, D7250)
Year you began this procedure (YYYY) _____</p> | <p><input type="checkbox"/> Sinus Lifts</p> <p><input type="checkbox"/> Palatal Inserts
Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Nerve Grafts</p> <p><input type="checkbox"/> Cleft Lip and Palate Surgery</p> <p><input type="checkbox"/> Face Lifts</p> <p><input type="checkbox"/> Management of Malignant Lesions</p> <p><input type="checkbox"/> Orthognathic Surgery</p> <p><input type="checkbox"/> Rhinoplasty</p> <p><input type="checkbox"/> Skin Peels</p> <p><input type="checkbox"/> Spa Services
Please explain _____</p> <p><input type="checkbox"/> TMJ Surgery</p> <p><input type="checkbox"/> Arthroscopy</p> <p><input type="checkbox"/> Implant</p> <p><input type="checkbox"/> Reconstruction</p> <p><input type="checkbox"/> Trigger Point Injections</p> <p><input type="checkbox"/> Other
Please explain _____</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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.

	<u>Informed Consent Type</u>	<u>Training</u>
<input type="checkbox"/> Orthodontic Full Mouth Banding	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Surgical Placement of Implant Fixtures	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Partially Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Fully Impacted Third Molar Extractions	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Nitrous Oxide Analgesia	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> General Anesthesia/Unconscious Sedation	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Facial Surgery	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections)	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> None
<input type="checkbox"/> Other (Please explain) _____	<input type="checkbox"/> Written <input type="checkbox"/> Oral <input type="checkbox"/> None	<input type="checkbox"/> CE <input type="checkbox"/> Post Grad <input type="checkbox"/> 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 Type: (You can only select one box.)

Solo Unincorporated/Sole Proprietor
 Solo Incorporated
 Multi-Shareholder Corporation, Partnership, Limited Liability Company
 Other (Please explain) _____

Organization Type (You must select at least one box.)

Licensed Dental Surgery Center
 Clinic Receives Governmental Immunity
 Mobile Dental Practice
 Nursing Home Based Practice
 Dental School - Faculty
 Clinical supervision of students
Hours per week _____
 Dental Students/Residents
 Other (Please explain) _____

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 MedPro RRG Risk Retention Group?

If yes, please provide MedPro RRG Risk Retention Group 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 Medical Protective 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 MedPro RRG Risk Retention Group'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 MedPro RRG Risk Retention Group ("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.

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 Signed _____

Type or Print Name _____

MEDPRO RRG Risk Retention Group Subscriber Agreement and Power of Attorney

WHEREAS, the undersigned subscriber ("Subscriber") acknowledges and agrees that this Subscriber Agreement and Power of Attorney ("Subscriber Agreement") (along with other subscriber agreements) constitute the charter of MEDPRO RRG Risk Retention Group ("MEDPRO RRG") and that the subscribers to MEDPRO RRG from time to time shall together comprise the reciprocal insurer, which shall operate through its Attorney-in-Fact as provided in this Subscriber Agreement as a risk retention group in accordance with federal law and as a risk retention group in the form of a reciprocal captive insurer in accordance with District of Columbia law.

NOW THEREFORE, in consideration of similar agreements executed or to be executed by other subscribers and of the benefits of the exchange of such agreements and of the terms of this Subscriber Agreement, the Subscriber agrees to the following terms and conditions.

1. **Appointment and Powers and Duties of Attorney-In-Fact.** Subscriber agrees to the appointment of MedPro Risk Retention Services, Inc., an Indiana corporation ("Attorney-in-Fact"), as the Attorney-in-Fact for MEDPRO RRG to carry out the purposes and objectives set forth in this Subscriber Agreement and to carry out all business on behalf of MEDPRO RRG and the subscribers thereto. Attorney-in-Fact is vested with all necessary power and authority to act on behalf of MEDPRO RRG and the subscribers thereto, including conducting the affairs of MEDPRO RRG, managing and operating (directly or through contract with third parties (including affiliates of Attorney-in-Fact)) MEDPRO RRG for the benefit of the subscribers, and causing the issuance and exchange of indemnity, insurance or reinsurance contracts with other subscribers.
2. **Limitations of Liability.**
 - a. The financial liability of Subscriber shall be limited to the amount of annual premiums on any contracts of indemnity, insurance or reinsurance due from Subscriber, provided, however, that all contracts of indemnity, insurance or reinsurance shall contain a "limit of liability" and in the event it is determined that Subscriber's liability on a claim under said contract of indemnity, insurance or reinsurance exceeds the limit of liability, such excess amount shall be the sole and complete responsibility of Subscriber.
 - b. Should any suit, legal proceeding or other action be brought against Attorney-in-Fact resulting from or arising out of Subscriber's obligation on any contract of indemnity, insurance or reinsurance that Subscriber may enter into, then and in that event, any and all judgments entered against Attorney-in-Fact in that capacity shall be deemed a legal judgment against Subscriber.
3. **Maintenance and Distribution of Surplus.** Attorney-in Fact shall cause MEDPRO RRG to maintain surplus in an amount sufficient to provide for the financial integrity of MEDPRO RRG and in an amount satisfactory to the District of Columbia Department of Insurance, Securities and Banking. In no event, however, shall Attorney-in-Fact be required to contribute its own assets or the assets of any affiliate to MEDPRO RRG.
 - a. Subscriber authorizes Attorney-in-Fact to accrue for the benefit of MEDPRO RRG and the subscribers net income and savings realized from the exchange of contracts of indemnity, insurance or reinsurance hereunder and the management of MEDPRO RRG and its assets.
 - b. Subject to the laws of the District of Columbia, if MEDPRO RRG is dissolved by Attorney-in-Fact, Attorney-in-Fact shall, after the full satisfaction of all liabilities and surplus notes of MEDPRO RRG from MEDPRO RRG's assets, pay each subscriber then insured an equitable share of all remaining assets, which payment shall be in full satisfaction of all rights and interests of such subscribers. Amounts to be paid to subscribers shall be distributed on an equitable basis as determined by Attorney-in-Fact.

4. **Term of Subscriber Agreement.**

a. This Subscriber Agreement shall have no fixed term and begins with the commencement of the policy period of any contract of indemnity, insurance or reinsurance issued hereunder to Subscriber and ends upon cancellation or other termination of such contract of indemnity, insurance or reinsurance or upon replacement of this Subscriber Agreement by a modified subscriber agreement provided by Attorney-in-Fact. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements.

b. Subscriber agrees that this Subscriber Agreement is expressly limited to the uses and purposes herein expressed and to no other. This Subscriber Agreement may be terminated by Subscriber or by Attorney-in-Fact upon 30 days written notice. The Subscriber's appointment of Attorney-in-Fact and Subscriber's obligations and authorizations under this Subscriber Agreement shall survive the termination of this Subscriber Agreement until any and all claims involving the indemnity, insurance or reinsurance contracts of the Subscriber and any and all other matters existing between the Subscriber and MEDPRO RRG, the Attorney-in-Fact or with third parties have been settled or satisfied. Subscriber agrees that the Attorney-in-Fact shall have the authority and ability to perform all duties and carry out all obligations during any extended reporting or tail coverage endorsements during the term of this Subscriber Agreement or after termination.

c. After termination of this Subscriber Agreement, Subscriber shall have no rights to participate in any distribution of assets upon dissolution of MEDPRO RRG.

5. **Replacement of Attorney-in-Fact.** Attorney-in-Fact may resign as Attorney-in-Fact upon designation by Attorney-in-Fact of a successor attorney-in-fact and 60 days written notice to existing subscribers. Any such successor attorney-in-fact shall have all the powers, rights and duties provided for in this Subscriber Agreement, and this Subscriber Agreement shall remain in full force and effect with such successor attorney-in-fact.
6. **Principal Office.** The principal office of MEDPRO RRG shall be maintained in the District of Columbia or at such other place as designated by Attorney-in-Fact.
7. **Limitation of Liability of Attorney-in-Fact.** Subscriber agrees that no officer, director, or employee of Attorney-in-Fact shall be personally liable to MEDPRO RRG or its subscribers for any breach of duty owed to MEDPRO RRG or its subscribers, provided however that this provision shall not relieve an officer, director or employee from liability for any breach of duty based on an act or omission (a) in breach of such person's duty of loyalty to MEDPRO RRG and its subscribers; (b) not done in good faith or involving a knowing violation of law; or (c) resulting in receipt by such person of an improper personal benefit. Such officers, directors and employees of Attorney-in-Fact shall be entitled to indemnification and advancement of expenses subject to the same exceptions recited above.
8. **Nature of MEDPRO RRG.** Subscriber acknowledges that MEDPRO RRG is a risk retention group organized in the District of Columbia as a reciprocal captive insurer and as such its contracts of indemnity, insurance or reinsurance are not subject to all state insurance laws and regulations. Further, state insolvency or guarantee funds are not available to risk retention groups, like MEDPRO RRG. Subscriber also acknowledges that MEDPRO RRG is a reciprocal organization under which each subscriber exchanges insurance obligations with the other subscribers through an attorney-in-fact.
9. **Governing Law.** This Subscriber Agreement shall be governed by and interpreted according to the laws of the District of Columbia without giving effect to the conflict or choice of law provisions of that or any other jurisdiction.

Subscriber Signature

IN WITNESS WHEREOF, the Subscriber has caused this Subscriber Agreement to be executed individually or by its duly authorized officer, as applicable, as of the __ day of _____, 20__.

SUBSCRIBER

By _____

Date: _____

Name and Title

Acceptance

MedPro Risk Retention Services, Inc., an Indiana corporation, Attorney-in-Fact for MEDPRO RRG Risk Retention Group, hereby accepts this Subscriber Agreement from Subscriber.

ATTORNEY-IN-FACT

By  _____
Trent Heinemeyer – Vice President and Secretary