

APPLICATION ADDENDUM FOR NEBRASKA PHYSICIANS



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Name: _____

This form must be completed annually.

1 Do you currently perform or intend to perform within the next 12 months any of the following procedures?

	Currently Perform	Intend to Perform	Do Not Perform
A. Refractive surgery to treat myopia, astigmatism, hyperopia, or presbyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Liposuction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Full facelifts for cosmetic purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Rhinoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Mentoplasty or genioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Harvest of an extensor tendon from the foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Harvest of a rib graft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Micropigmentation of the breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Placement of arch bars on teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Remote screening, in the absence of a live examination by a qualified ophthalmologist, for retinopathy of prematurity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. LipoDissolve, mesotherapy, or similar procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2 Do you perform any of the following for reasons other than treatment of an ophthalmic condition or disease?

- | | | |
|---|---|--|
| <input type="checkbox"/> Endoscopic sinus surgery | <input type="checkbox"/> Facial reanimation | <input type="checkbox"/> Harvest of a bone graft |
| <input type="checkbox"/> Harvest of ear cartilage | <input type="checkbox"/> Septoplasty | |

3 Do you perform or intend to perform any clinical research or trials **other than those conducted under and in accordance with an American IRB-approved protocol?** Yes No

4 Are you affiliated with a medical spa in any of the following capacities? No

- | | | |
|--|---|---|
| <input type="checkbox"/> Owner or operator | <input type="checkbox"/> Medical Director | <input type="checkbox"/> Supervising or prescribing physician |
|--|---|---|

5 Do you serve as proprietor, superintendent, executive officer, administrative officer, medical staff officer, medical director, or Board member of any of the following?

- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Clinic with bed and board facilities | <input type="checkbox"/> Hospital | <input type="checkbox"/> HMO |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Sanitarium | <input type="checkbox"/> Other medically related enterprise |

6 Are you employed by any governmental agency (excluding volunteer work or work as an independent contractor)? Yes No

7 Do you co-manage the postoperative care of your surgical patients? Yes No

If yes:

A. Do you verify that the providers with whom you co-manage are clinically competent and lawfully able to provide postoperative care? Yes No

B. Do you obtain the patient's written informed consent for planned co-management prior to surgery? Yes No

C. Do you monitor the postoperative care provided by the other providers, maintaining communication regarding frequency of visits, exams performed, and outcomes of all exams? Yes No

8 Have you had any significant changes in your practice activities during the past 12 months? Yes No

If yes, please explain: _____

You must notify OMIC 60 days in advance of any intended changes to your responses above, such as the intention to begin performing any of the procedures listed in Question 1 above, and of any intended changes to your responses on the standard OMIC application or renewal application. Failure to notify OMIC of intended changes could result in cancellation or non-renewal of your coverage or denial of a claim related to the change(s). Changes in practice activity or other coverage changes may result in modification to your premium as of the effective date the change takes place.

Applicant's Signature

Date