

SUPPLEMENTAL QUESTIONNAIRE FOR OPTICAL SHOP



**OPHTHALMIC MUTUAL
INSURANCE COMPANY**
(A Risk Retention Group)

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The policy to which this application applies is issued by Ophthalmic Mutual Insurance Company (A Risk Retention Group). Risk retention groups may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.

If the optical shop is a partnership or corporation, no coverage exists until Declarations listing the entity as an insured are issued.

If approved for coverage, the optical shop and its employees will share liability limits with the owner-ophthalmologist/entity. No additional premium applies.

Please PRINT or TYPE your answers and personally sign and date the warranty, authorization, and prior claims information supplement. Signature stamps are not acceptable.

Please answer all questions COMPLETELY, including any additional comments required, since incomplete information may delay processing. If a question does not apply, use N/A.

1 A. Under what name does the optical shop conduct business? _____

B. Is this the optical shop's legal business name or a fictitious business name (dba)?

2 A. Contact person's name: _____

B. Title: _____ C. Email: _____

3 A. Physical address: _____

City State County Zip code

B. Phone: () _____ C. Fax: () _____

D. Mailing address (if different from above): _____

City State County Zip code

4 What is the legal structure of the optical shop?

- Sole proprietorship (unincorporated) Sole shareholder corporation Partnership
 Multi-shareholder corporation Limited liability partnership Limited liability corporation

5 Date optical shop incorporated/opened for operation? _____

6 Please list the name, specialty (if physician) or professional designation (if non-physician), and percentage of ownership for each owner of the optical shop. OMIC insureds, their immediate families, or both, must hold at least 50% of the ownership in the facility.

Name	Specialty/Designation	Percentage of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____

Continue in the **Comments** section, if needed.

HIPAA DISCLOSURE

Under the HIPAA Privacy Rules, you may disclose protected health information (“PHI”) without patient authorization to medical professional liability insurers in order to obtain or maintain insurance coverage. OMIC will (1) maintain the confidentiality of PHI you provide to us, (2) use it only for purposes for which it was disclosed, and (3) notify you of any breach of confidentiality of PHI. If OMIC insures you, OMIC will become your business associate and will safeguard PHI in accordance with OMIC’s Business Associate Agreement.

ARBITRATION CLAUSE

The OMIC professional and limited office premises liability policy contains an Arbitration Clause. By accepting the policy coverage, you will be bound by the terms of the Arbitration Clause. This Clause states that any dispute you have with OMIC arising out of the policy must be submitted exclusively to final and binding arbitration. Under the Clause, you agree not to proceed against OMIC in state or federal court and specifically acknowledge waiving your right to a jury trial. Any arbitration award rendered will be final and not subject to appeal. Arbitration will take place in any jurisdiction that is convenient to you and agreed to by the parties. Each party pays its own arbitration costs and the fees of its selected arbitrator and they share equally in the fees of the neutral arbitrator and any other arbitration costs. You must keep confidential the nature of the arbitration proceeding and the award.

WARRANTY, ACCEPTANCE OF POLICY TERMS, AND RELEASE

I understand that for purposes of insurance coverage all statements contained in this application are considered material to the issuance of coverage. I warrant that the information furnished as a part of this application is true to the best of my knowledge and is furnished in good faith and that no material information has been withheld. I agree to update this application while it is pending should there be any change in the information provided, and to update such information if and after OMIC extends insurance coverage. I understand that failure to comply with the above may result in a declination or termination of coverage or denial of coverage for a claim. I understand that this application and any other documents submitted to OMIC for insurance coverage, together with the policy, the Declarations, and any endorsements, will constitute the contract of insurance between OMIC and the optical shop. I consent to the communication of summary information between the claims and underwriting departments for periodic underwriting review. I understand that coverage does not become effective until this application is approved and (if the optical shop is a separate entity) Declarations listing the optical shop as an insured are issued.

I consent to the communication of information and documents between OMIC and other insurance companies, credentialing organizations, certification organizations, professional associations, licensing agencies, and other persons who may have information pertaining to this application, the optical shop’s qualifications for insurance, or claims under review. I release from liability, to the fullest extent allowed by law, OMIC and its agents and representatives and all individuals and organizations who provide information and documents to OMIC for their acts performed in connection with evaluating this application, the optical shop’s qualifications for insurance, and claims under review.

Signature of Authorized Representative
(Please do not use signature stamp.)

Title

Authorized Representative’s Name

Date

PRIOR CLAIMS INFORMATION SUPPLEMENT

Complete one form for each incident, claim, or suit. If you need additional space, please attach a separate page. Copy this form if more than one claim is being reported. Please type.

- 1** Name and Designation of Health Care Provider: _____
- 2** Name of Patient/Claimant: _____
- 3** Date(s) of Treatment: _____ Date of Claim/Suit: _____
- 4** Claimant's Allegation: _____
- 5** Name of Insurance Carrier Providing Defense: _____
- 6** Additional Defendants: _____
- 7** Status: Incident (reported to carrier on a precautionary basis only; verbal allegation or demand made)
 Claim (written demand made; notice of intent received; or other cases classified by your carrier as a claim)
 Suit (summons and complaint served)

- 8** Chronologic summary of events (including nature of treatment and your involvement). Your chronological summary of events should provide sufficient detail from which OMIC can make an independent assessment of the care rendered.
If case is still pending or indemnity has been paid, attach copies of patient charts and operative notes.

(Continue in the **Comments** section, if necessary. Be sure to sign and date any additional pages.)

- 9** Disposition of claim:
- Open **If open**, has the carrier indicated a desire to settle? Yes No
- Closed Amount of Settlement/Judgment: \$ _____ Date closed: _____

NOTE: This policy will not apply to any claim arising from any professional services incident occurring prior to the effective date of the first policy issued to the applicant and continuously renewed thereafter if the applicant was aware of or could have reasonably known at the time of application that a claim or suit could develop from that incident.

"I understand that information submitted herein becomes part of the Supplemental Questionnaire for Optical Shop."

Signature of Authorized Representative
(Please do not use signature stamp.)

Title

Authorized Representative's Name

Date