APPLICATION FOR SLOT COVERAGE—RESIDENT OR FELLOW

OMIC
OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco CA 94109-1336

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San Francisco CA 94188-0610

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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.

No coverage exists until Declarations listing you as an insured are issued.

Please PRINT or TYPE your answers and personally sign and date the warranty and disclosure form. Signature stamps are not acceptable.

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

1 Your Name: ______________________________
First *Middle* *Last* *Suffix*

2 Date of Birth: ______________________________

3 Medical License Number: ____________________ State: ____________________

4 Name of the physician/entity with whom you will be training: ______________________________

5 **A.** Address at which you will be working: ______________________________

____
City *State* *County* *Zip code*

B. Office Phone: (   ) ____________ **C.** Fax: (   ) ____________ **D.** Email: ____________

6 Training capacity: **A.** ☐ Resident ☐ Fellow *(list subspecialty)*: ____________

B. ☐ First Year ☐ Second Year ☐ Third Year

7 Requested effective date of coverage: ______________________________

8 **A.** Medical School: ______________________________

B. Country: ____________ **C.** Year Graduated: ____________ **D.** Degree: ____________

9 Internship: ______________________________
Hospital *City* *State*

From: ____________________ To: ____________________
Month/Year *Month/Year*

10 Prior Residency *(if any)*: ______________________________
Hospital *City* *State*

From: ____________________ To: ____________________
Month/Year *Month/Year*

11 Current hospital staff privileges:

A. Hospital: ______________________

Address: ______________________

____
City State County Zip code

Type of Privileges *(active, courtesy, etc.)*: ______________________

B. Hospital: ______________________

Address: ______________________

____
City State County Zip code

Type of Privileges *(active, courtesy, etc.)*: ______________________

12 On **average,** how many hours per week will you practice? ______________________

13 How many patients will you encounter on an **average** day of clinical practice? ______________________

14 Please check which, if any, of the following cosmetic procedures your training will include:

☐ Full cosmetic facelifts ☐ Liposuction ☐ Rhinoplasty

15 Please check which, if any, of the following refractive procedures your training will include:

☐ RK/AK ☐ PRK/LASIK ☐ CK ☐ LTK ☐ Refractive Lens Exchange

☐ Intacs ☐ Phakic implants for refractive purposes ☐ Other *(specify)*: ______________________

If you indicated any of the procedures listed in questions 14 and 15, a **supplemental questionnaire** for each procedure checked will be forwarded to you for completion. No coverage for any of these procedures applies until the applicable questionnaire has been reviewed, approved, and endorsed to your policy.

16 Will you provide ROP care (screening or treatment) to infants less than 50 weeks postmenstrual age (gestational age plus postnatal age)? ☐ Yes ☐ No

If yes, a **supplemental questionnaire** will be forwarded to you for completion.

If you answer "yes" to any of questions 17 through 22 below, please provide complete details.

17 Are you now or have you ever been addicted to alcohol, dependent upon narcotics or other chemicals, or been affected by mental illness or treated for any such condition? ☐ Yes ☐ No

18 Do you have **any** medical condition which might impair your ability to practice ophthalmology? ☐ Yes ☐ No

19 Have you ever been convicted of, or plead guilty or no contest to, a felony or misdemeanor, including driving under the influence (DUI) or driving while intoxicated (DWI), other than minor traffic offenses? ☐ Yes ☐ No

20 Has **any** investigation, revocation, suspension, restriction, or other disciplinary action, or change in status ever occurred with respect to your license to practice, your BNDD (DEA) license, your privileges or participation at any hospital, health maintenance organization, or other medical facility, or your certification by or membership in any medical association, medical society, or medical board? ☐ Yes ☐ No

21 Has a fee complaint or professional conduct complaint ever been registered against you? ☐ Yes ☐ No

22 **A.** Have **any** professional liability claims or suits **ever** been brought against you *(regardless of merit)*? ☐ Yes ☐ No

B. Are you aware of **any** facts or circumstances which may give rise to a claim or suit in the future? ☐ Yes ☐ No

HIPAA DISCLOSURE

Under the HIPAA Privacy Regulations, 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 the 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 document(s) submitted to OMIC for insurance coverage, together with the policy, the Declarations, and any endorsements, will constitute the contract of insurance between OMIC and me. 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, the required premium for this insurance has been paid, and Declarations listing me as an insured are issued.

I consent to the communication of information and documents between OMIC and other insurance companies, hospitals, teaching institutions, professional associations, licensing agencies, and other persons who may have information pertaining to this application, my 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 my application, my qualifications for insurance, and claims under review.

______________________________ *Applicant's Signature (Please do not use signature stamp.)*

______________________________ *Date*

______________________________ *Print Name*

DISCLOSURE FORM: CLAIMS MADE AND REPORTED POLICY

IMPORTANT NOTICE TO INSUREDS

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT MERELY DESCRIBES SOME OF THE MAJOR FEATURES OF OMIC'S CLAIMS MADE AND REPORTED POLICY. READ YOUR POLICY CAREFULLY TO DETERMINE YOUR RIGHTS AND DUTIES AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

Your policy is a claims made and reported policy. It applies only to claims made against you and reported to OMIC after the inception date and within five days after the end of the policy period arising from professional services incidents that occur on or after the policy retroactive date. Upon termination of your policy, an extended reporting period may be available.

OCCURRENCE VS. CLAIMS MADE AND REPORTED

"Occurrence" and "claims made and reported" policies generally cover the same kinds of professional services incidents. However, claims for damages may be assigned to different policy periods depending on which policy you have.

In an "occurrence" policy, coverage is provided for liability because of professional services incidents that *occur during the policy period, no matter when the claim is made.*

In your "claims made and reported" policy, coverage is provided for liability because of professional services incidents *if the claim is first made against you and reported to OMIC during the policy period or within five days after the end of the policy period.* The claim must be a written notice or demand that you have received arising from an act, error, or omission in the provision of services. A claim is considered made when it is received by you and reported when it is received by us. A claim may be assigned to an earlier policy period if, for example, another claim based on the same professional services incident has already been made during the earlier policy period.

PRINCIPAL BENEFITS, CONDITIONS, EXCLUSIONS, AND RESTRICTIONS

The policy provides coverage for professional and limited office premises liability up to the maximum dollar limit specified in the policy and the policy Declarations. The principal benefits and coverages are explained in detail in your claims made and reported policy. The policy also contains certain conditions, exclusions, and restrictions. Please read your policy carefully and consult your attorney, insurance advisor, or risk management consultant for any questions you might have.

RENEWALS, RETROACTIVE DATES, AND EXTENDED REPORTING PERIODS

Your claims made and reported policy has some unique features relating to renewal, coverage of incidents with long periods of exposure, and extended reporting periods. These special provisions are described below.

Renewal

Your premium may increase or decrease upon renewal. You will receive notification in accordance with the terms of your policy.

Retroactive Date

When you have a retroactive date entered on the Declarations page, there is no coverage for professional services incidents that occur before the retroactive date, even if the claim is first made and reported during the policy period. If there is no retroactive date entered on the Declarations page, the policy will respond to claims first made during the policy period or within five days after the end of the policy period for covered professional services incident, no matter when the incident occurred.

If there is a retroactive date, it cannot be moved ahead in time except with your written consent and only under certain circumstances, including the following: you have changed insurers; there is a substantial change in your operations that increases your exposure to loss; or you have failed to provide us with information about the nature of your business or premises. It is important to understand how the claims made and reported policy's extended reporting period guarantees continuity of coverage if you are offered a renewal or replacement policy with a later retroactive date than the one in your current policy.

Extended Reporting Periods or "Tails"

If a claim is made and reported more than five days after the termination of your claims made and reported policy, you may not have coverage for that claim. Insured ophthalmologists, slots, and professional entity Policyholders may purchase an extended reporting period or "tail" endorsement, which will be offered with at least the aggregate limit of the Insured's terminated policy and will allow reporting for at least one year after the end of the policy. Carefully review the policy provisions regarding the available extended reporting period and the time during which you must purchase or accept any offered extended reporting period endorsement.

If the coverage under this policy of any Insured non-physician employee or locum tenens terminates, he or she will continue to be covered for claims based on incidents that occurred while the employee or locum tenens was employed by the Insured ophthalmologist or professional entity, even if the claim is not reported until after the employee or locum tenens is no longer employed, so long as the claim is first made and reported to OMIC within the policy period or extended reporting period applicable to the employer Insured. Limits of liability for the claim will be shared with the employer Insured.

If the coverage under this policy of any Insured professional entity that shares limits with another Insured terminates by reason of the dissolution or other termination of activity of the professional entity, the professional entity will continue to be covered for claims based on incidents that occurred while such professional entity was active, even if any such claim is not reported until after the professional entity ceases activity, so long as the claim is first made and reported to OMIC within the policy period or extended reporting period applicable to the Insured with which the professional entity shares limits.

____ ________________________________

Applicant's Signature (Please do not use signature stamp.) *Date*

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Print Name