APPLICATION FOR ENTITY PROFESSIONAL LIABILITY INSURANCE COVERAGE

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
A Risk Retention Group

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San Francisco CA 94188-0610

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This application does not apply to outpatient surgical facilities or medical spas. If this entity is a surgery center or refractive surgery center, please complete a Supplemental Outpatient Surgical Facility Questionnaire. If this is a medical spa, please complete a Supplemental Medical Spa Questionnaire. You may download the required questionnaire from OMIC's website, www.omic.com, or contact an underwriting representative.

GENERAL INFORMATION

1 Entity's legal name: _____

2 A. Other name(s) under which you currently do business: _____

B. Other name(s) used in the past: _____

3 Contact person's name: _____ Title: _____

Office Phone: ( ) _____ Fax: ( ) _____ Email: _____

Practice website address (URL): _____

4 Mailing Address: _____

_____

City *State* *County* *Zip code*

Billing Address: ☐ Same as Mailing ☐ Other listed below

_____

_____

City *State* *County* *Zip code*

5 Federal Tax ID: _____

OWNERSHIP AND BUSINESS OPERATIONS

6 Date of incorporation/establishment: _____

7 Is the primary purpose of this entity the operation of the owner's ophthalmology practice? ☐ Yes ☐ No

If no, describe the nature of your business operations: _____

_____

8 Are there any owners who are not ophthalmologists? ☐ Yes ☐ No

If yes, please provide the name and specialty/professional designation of each non-ophthalmologist owner and the total percentage of ownership held by non-ophthalmologists: _____

_____

9 Do each of the physician owners personally provide clinical services on behalf of this entity?

☐ Yes ☐ No

If no, please explain: _____

10 Please indicate which, if any, of the following the practice owns or operates. Also indicate whether you maintain liability insurance for the facility under a separate policy.

Type of Facility	Own/Operate?	Separately Insured?
Optical shop that is separately incorporated	☐ Yes ☐ No	☐ Yes ☐ No
Outpatient surgical facility (i.e., an in-office surgical suite used by physicians who are not members of your practice, a surgery center, or a refractive surgery center)	☐ Yes ☐ No	☐ Yes ☐ No
Medical spa (i.e., a business that is incorporated or marketed separately from the ophthalmology practice, for the purpose of delivering cosmetic treatments)	☐ Yes ☐ No	☐ Yes ☐ No

11 Do you conduct clinical trials? ☐ Yes ☐ No

PRACTICE LOCATIONS

12 Please indicate the county(ies)/state(s) in which you are located and the number of office locations in each.

County	State	No. of Locations
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL (MD) AND OSTEOPATHIC (DO) DOCTORS

13 Please list each medical (MD) or osteopathic (DO) doctor in the practice and his/her status using the status codes below. If any of the physicians are not ophthalmologists, please indicate their medical speciality. Continue on a separate page if there are additional practice affiliates. **If any members are not insured by OMIC, submit a copy of the Declarations page from their current policy and a "loss history"/"claims experience" report.**

Status codes: O — Owner; **E** — Employee; **I** — Independent Contractor; **S** — Share Office

Name	Status	Speciality (if not ophthalmology)
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____

OPTOMETRISTS

14 Please list each optometrist in the practice and his/her status code (see question 13 above).

Name	Status Code (O, E, I, S)

15 **Submit a current certificate of insurance** for each optometrist above who is not insured by OMIC.

16 Do any of the optometrists affiliated with your practice perform any procedures other than use of diagnostic lasers (e.g., OCT), gonioscopy, adult diagnostic canalicular probing or irrigation under topical anesthetic, adult punctal dilation, conjunctival swab for cultures, bandage contact lenses, placement of self-retaining amniotic membrane tissue for FDA-approved indications, punctal closure with plugs, thermal pulsation for chronic cystic conditions of the eyelids, microblepharoexfoliation, epilation (mechanical, electrical or photo), removal of superficial foreign bodies from the cornea or conjunctiva, and removal of sutures from the lid or adnexa?

☐ Yes ☐ No ☐ N/A—no affiliated optometrists

If yes, please list other procedures performed: _____

_____

ADVANCED PRACTICE PROVIDERS

17 Please specify the number of advanced practice providers you employ or contact with:

☐ None - Or

Category	Employed	Contracted
Physicians Assistants (PA)	_____	_____
Nurse Practitioners (NP)	_____	_____
Surgical Assistants (SA)	_____	_____
Nurse Anesthetists (CRNA)	_____	_____

18 Would you like to insure your employed CRNA(s) under your policy? ☐ Yes ☐ No

19 **Submit a copy of the current insurance policy Declarations page for each contractor listed above and for employed CRNAs insured under a separate policy.**

PREVIOUS INSURANCE AND CLAIMS/COMPLAINT INFORMATION

20 List the names of all professional liability insurance carriers that have insured you during the past five years and the dates of such coverage. *(Continue on a separate page, if necessary.)*

A. Carrier: _____ From: _____ To: _____

Mailing Address: _____

B. Carrier: _____ From: _____ To: _____

Mailing Address: _____

21 Within the past 10 years, has any medical professional liability insurer canceled, declined coverage, non-renewed, or otherwise restricted your coverage, or have you ever withdrawn your application for coverage or voluntarily canceled due to unfavorable underwriting review? ☐ Yes ☐ No

If yes, please specify the action taken and reason for such action. Also submit a copy of any correspondence between you and the carrier concerning this action. ☐ Yes ☐ No

22 **Attach a copy of the entity's current insurance policy Declarations Page(s) and all applicable Endorsements.**

23 Has a fee complaint or professional conduct complaint ever been registered against the entity or its non-physician employees? ☐ Yes ☐ No

If yes, please provide a copy of the complaint, your response, and, if resolved, the final resolution. For professional conduct complaints, also submit copies of the patient charts and (if applicable) operative notes.

If you answer "yes" to any questions 24 through 26, please complete a separate **Prior Claims Information Supplement** for each circumstance.

24 Have any professional liability claims been brought against the entity or its non-physician employees within the past 10 years *(regardless of merit)*?

☐ Yes, Number: _____ ☐ No

25 Are there any older professional liability claims that are still pending against the entity or its non-physician employees?

☐ Yes, Number: _____ ☐ No

26 Are you aware of **any** facts or circumstances that may give rise to a claim, regardless whether it has been reported to your current or previous carrier? ☐ Yes ☐ No

27 Attach, or forward as soon as possible, a "loss history"/"claims experience" report for the entity **provided by your insurance carrier.**

REQUESTED COVERAGE INFORMATION

28 What is your requested effective date of coverage? _____

(Please note that your actual policy effective date may be different, subject to OMIC's underwriting rules.)

29 If your current coverage is on a **claims-made basis,** does the entity wish to buy **prior acts coverage** from OMIC (ie., coverage for claims arising from services rendered on or after your retroactive date and before your effective date with OMIC that haven't already been reported to another insurance carrier)?

☐ Yes ☐ No ☐ N/A - current coverage is occurrence

If yes, what is the entity's retroactive date? _____

If no, does the entity intend to purchase extending reporting endorsement ("tail") coverage from its present carrier?

☐ Yes ☐ No

30 Check the limits of liability you would like.

☐ $100,000/$300,000 (Louisiana only)
☐ $200,000/$600,000 (Kansas, South Carolina only)
☐ $500,000/$1,000,000 (Nebraska only)
☐ $500,000/$1,500,000
☐ $1,000,000/$3,000,000
☐ $2,000,000/$4,000,000
☐ $5,000,000/$10,000,000
☐ Other (specify): _____

The entity's liability limits can be no higher than the limits carried by its physician members.

Sole shareholder corporations generally share liability limits with the owner ophthalmologist. Do you desire separate liability limits for your sole shareholder corporation? ☐ Yes ☐ No ☐ Not applicable

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 safeguard PHI you disclose to it in accordance with OMIC's HIPAA Business Associate Agreement.

RISK RETENTION GROUP NOTICE

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.

Wisconsin applicants only: Under the Federal Liability Risk Retention Act of 1986 (15 USC 3901 to 3906), the Wisconsin insurance security fund is not available for payment of claims if this risk retention group becomes insolvent. In that event, you will be personally liable for payment of claims up to your limit of liability under s. 655.23 (4), Wis. Stat.

Kansas applicants only: Basic medical malpractice coverage required by K.S.A. 40-3402 purchased from a risk retention group is different from coverage purchased from an insurance company. Risk Retention groups are created under federal law and are not subject to all of the insurance laws and regulations of the state of Kansas. Federal and state laws prohibit risk retention groups from participating in the Kansas Insurance Guaranty Association. Therefore, in the event of a risk retention group insolvency, the risk retention group insured will not have insurance and may be personally responsibile for the defense costs and the first $200,000 of any settlement or judgment which may result from a claim or medical malpractice.

ARBITRATION CLAUSE NOTICE

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.

CLAIMS MADE AND REPORTED POLICY DISCLOSURE

Your policy is a claims made and reported policy. It applies only to claims made against you and reported to OMIC during the policy period or within five days after the end of the policy period arising from professional services incidents that occur on or after the policy retroactive date. A claim is considered made when it is received by you and reported when it is received by OMIC. Upon termination of your policy, an extended reporting period may be available. Carefully review the extended reporting period policy provisions and when you must purchase or accept any offered extended reporting period endorsement.

WARRANTY AND ACCEPTANCE OF POLICY TERMS

I understand that for purposes of insurance coverage all statements contained in this application and all supplemental questionnaires are considered material to the issuance of coverage. I warrant that the information I have provided is true to the best of my knowledge and is given in good faith and that I have not withheld any material information.

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 based on the false or undisclosed information. (Denial of coverage does not apply to Wisconsin Injured Patients and Families Compensation Fund participants.)

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 entity.

I acknowledge that as part of the ongoing underwriting review of the entity's insurance coverage with OMIC, certain information pertaining to any open or closed claim made under the entity's OMIC policy may be reviewed in determining whether coverage may be continued, and I consent to the communication of summary information between the claims and underwriting departments.

I understand that the entity is not insured and coverage is not effective until this application is approved, the required premium for the insurance has been paid, and Declarations listing the entity as an insured are issued.

Once insured, the entity will be bound by the terms of the insurance policy issued it. I have read the policy included in the application materials carefully to determine the entity's rights and duties. I understand that I should discuss the coverage with my attorney, insurance advisor, or risk management consultant. By my signing this application as the entity's authorized representative, the entity agrees to be bound by the terms, conditions, exclusions, restrictions, and definitions of the OMIC professional and limited office premises liability insurance policy.

_____ _____

Signature of Authorized Representative *Title*

_____ _____

Authorized Representative's Name *Date*

AUTHORIZATION TO RELEASE INFORMATION

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, the entity'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 for their acts performed in connection with evaluating this application, the entity's qualifications for insurance, or claims under review.

I release from liability, to the fullest extent allowed by law, all individuals and organizations who provide information and documents to OMIC or its agents or representatives concerning this application, the entity's qualifications for insurance, or claims under review.

_____ _____

Signature of Authorized Representative *Title*

_____ _____

Authorized Representative's Name *Date*

MEMBERSHIP APPLICATION AND AGREEMENT—PROFESSIONAL ENTITY

For and in consideration of the benefits to be derived therefrom, the Applicant hereby applies for membership in the Ophthalmic Mutual Insurance Company (a Risk Retention Group) ("OMIC"), the principal office being located in the state of Vermont; and the main business office being located at 655 Beach Street, San Francisco, California 94109.

The Applicant hereby acknowledges that:

1. The undersigned professional entity, hereafter referred to as "the Applicant," represents and warrants that the entity provides predominantly eye care-related health services.
2. The Applicant understands that this membership is subject to acceptance by OMIC.
3. Membership begins with the commencement of the policy period of a claims made and reported insurance policy issued by OMIC, and ends upon the cancellation or other termination of that policy. The period of membership shall not include any period of coverage under extended reporting or tail coverage endorsements. After termination of membership, the member shall have no further right to participate in any distribution of savings to members or in any distribution of assets upon the dissolution of OMIC, except for amounts that may be due to the member for loans or surplus contributions under separate instruments issued by OMIC.
4. The Applicant, through its authorized representative, has read the Bylaws of OMIC and agrees that if the entity's application for insurance is accepted by OMIC, the Applicant shall at such time become a member of OMIC. Membership shall, among other things, evidence ownership in OMIC to the extent required by Vermont law governing

mutual insurance companies and risk retention groups. As a member of OMIC, the Applicant will be bound by the terms and conditions of the Bylaws of OMIC, as such may be amended from time to time.

_____ _____

Signature of Authorized Representative *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 of Applicant: _____

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; oral 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 on a separate page, 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 out of 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 Application for Entity Professional Liability Insurance Coverage."

_____ _____

Signature of Authorized Representative *Title*

_____ _____

Authorized Representative's Name *Date*