APPLICATION FOR ADDITIONAL INSURED EMPLOYED OPTOMETRIST

655 Beach Street
San Francisco CA 94109-1336

P.O. Box 880610
San Francisco CA 94188-0610

Phone: (800) 562-6642, ext. 639
Fax: (415) 771-7087

Email: omic@omic.com
Web: www.omic.com

1 Name: ____ O.D.
First Middle Last

2 Date of Birth: ____________________ 3 Gender: ☐ Male ☐ Female

4 Optometry School Attended: ____________________________________

City/State: ______________________________ From: __________ To: __________
(mo/yr) (mo/yr)

5 License Number: ______________________________ State: __________

License Number: ______________________________ State: __________

6 Employer: ____

Mailing Address: ____

____
City State County Zip code

Business Phone: ____________________ Email Address: ____________________

7 Effective Date of Employment: ____________________________________

8 A. How many hours per week do you work for the above? ____________________

B. Are you employed or otherwise practice elsewhere? ☐ Yes ☐ No

If yes, C. Name of other employer/practice: ______________________________

If approved, coverage will apply solely to professional services rendered within the scope of your training, licensure, and employment by the insured ophthalmologist or professional entity listed in question 6 above. You must maintain separate coverage for any professional services rendered outside of this employment.

Questions 9–13 pertain to your practice for the employer listed in question 6 above.

9 Do you practice in the same office as your employing ophthalmologist? ☐ Yes ☐ No

10 For each county and state in which you practice, please indicate the number of locations and average number of hours per week you practice.

County	State	Number of Locations	Hours/Week

11 Are you ☐ DPA ☐ TPA certified in your state?

12 Do you take call? (check all that apply)

☐ No ☐ For my employer's practice ☐ For a call group ☐ For the ER

Optometrists who take call must follow written protocols and must have appropriate backup. An ophthalmologist must always be available within a reasonable response time to take patient referrals in the event a situation that exceeds the optometrist's scope of expertise or legal scope of practice arises. Initial here to confirm your compliance with this requirement: ___________ ☐ n/a—do not take call

13 Do you 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 therapy 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

If yes, please list other procedures performed: ____

____

If you answer "yes" to any of questions 14 through 21 below, please provide complete details.

14 Within the past 10 years, has any professional liability insurer canceled, declined coverage, non-renewed, or otherwise restricted your coverage? ☐ Yes ☐ No
If yes, please attach copies of all correspondence between you and the carrier concerning this action.

15 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

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

17 Have you 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 within the past 10 years? ☐ Yes ☐ No

18 Has ***any*** investigation, disciplinary action, or negative change in status occurred with respect to your license to practice within the past 10 years? ☐ Yes ☐ No

19 Has a fee or professional conduct complaint been registered against you with your state board of optometry or other regulatory agency within the past 10 years? ☐ Yes ☐ No

20 Have any professional liability claims been brought against you within the past 10 years (regardless of merit)? ☐ Yes ☐ No

21 Are there any older professional liability claims pending against you? ☐ Yes ☐ No

22 List the names of all professional liability insurance carriers that have insured you during the past five years and the dates of such coverage.

A. Carrier: ______________________________ From: ______________ To: ______________

Mailing Address: ____

B. Carrier: ______________________________ From: ______________ To: ______________

Mailing Address: ____

Note: If your coverage is currently claims-made, you may need to purchase an extended reporting endorsement from your present carrier. Prior acts coverage is generally not available from OMIC.

23 What is your requested effective date of coverage with OMIC? ______________________________

24 Limits of liability will be shared with the employing ophthalmologist/entity unless otherwise specified. Do you desire separate limits of liability? ☐ 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 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.

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.

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 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. 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 me. I consent to the communication of summary information between the claims and underwriting departments for periodic underwriting review. I understand that I am not insured and coverage is not 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 for their acts performed in connection with evaluating my application, my qualifications for insurance, and claims under review, and all individuals and organizations who provide information and documents to OMIC for such evaluation.

____________________________________ ____________________

Applicant's Signature *Date*

____

Print Name