APPLICATION FOR ADDITIONAL INSURED EMPLOYED NURSE ANESTHETIST

OMIC
OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco CA 94109-1336
P.O. Box 880610
San Francisco CA 94188-0610
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Fax: (415) 771-7087
Email: omic@omic.com
Web: www.omic.com

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. 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 Name: _____, C.R.N.A.
First *Middle* *Last*

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

4 Nursing School Attended: _____

City/State: _____ From: _____ To: _____
Month/Year *Month/Year*

5 Nurse Anesthesia School Attended: _____

City/State: _____ From: _____ To: _____
Month/Year *Month/Year*

6 RN License Number: _____ State: _____

7 NBCRNA Certification Number: _____ Year certified/recertified: _____

Please attach a copy of your certification.

8 Employer: _____

Mailing Address: _____

_____
City *State* *County* *Zip code*

Business Phone: _____ Email Address: _____

9 Effective Date of Employment: _____

10 **A.** How many hours per week do you work for the above? _____

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

C. If yes, 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 8 above. You must maintain separate coverage for any professional services rendered outside of this employment.

11 Where do you render services? ☐ Doctor's Office ☐ Surgery Center ☐ Hospital

12 How many patients do you encounter on an average day of practice? _____

13 In what percentage of your cases do you administer the following type(s) of anesthesia?

☐ Regional _____% ☐ Intravenous Sedation _____% ☐ Retrobulbar _____%

☐ General _____% ☐ General on infants and toddlers _____%

14 What percentage of your cases are done with endotracheal intubation? _____%

15 What percentage of your cases are performed under the supervision of an anesthesiologist? _____%

If you answer "yes" to any of questions 16 through 23 below, please provide complete details.

16 Has any professional liability insurer ever canceled, declined coverage, refused renewal, or renewed your coverage under restrictive conditions? ☐ Yes ☐ No

If yes, please attach copies of all correspondence between you and the carrier concerning this action.

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 anesthesiology? ☐ 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, denial, other disciplinary action, or change in status ever occurred with respect to your license to practice? ☐ Yes ☐ No

21 Has a fee complaint or professional conduct complaint ever been registered against you with your state board of nursing or other regulatory agency? ☐ Yes ☐ No

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

23 Are there any other professional liability claims or suits pending against you? ☐ Yes ☐ No

24 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.

25 What is your requested effective date of coverage with OMIC? _____

26 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 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.

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 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 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 to all individuals and organizations who provide information and documents to OMIC for such evaluation.

_____ _____

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

_____

Print Name