APPLICATION FOR ENTITY PROFESSIONAL LIABILITY INSURANCE COVERAGE

OMIC
OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

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San Francisco CA 94109-1336

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San Francisco CA 94188-0610

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Email: omic@omic.com
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No coverage exists until Declarations listing you as an insured are issued.

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.

Please PRINT or TYPE your answers and personally sign and date the warranty, authorization, membership agreement, 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 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: _____

4 **A.** Primary Office Address: _____

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

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

E. Mailing Address *(if different from above)*: _____

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

F. Billing Address: Same as ☐ Primary Office ☐ Mailing ☐ Other listed below

_____

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

5 Date of incorporation/establishment: _____ 6 Federal Tax ID: _____

7 Describe the nature of your business operations: _____

_____

8 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**

9 How is the practice organized? *(Please check one.)*

☐ Partnership ☐ Multi-shareholder Corporation ☐ Sole Shareholder Corporation
☐ Limited Liability Partnership ☐ Limited Liability Corporation

10 Practice affiliation is: ☐ Ophthalmology-exclusive ☐ Multispecialty

11 Please list all of the medical or osteopathic doctors in the practice and the status of each. 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	Name	Status
A.		**D.**	
B.		**E.**	
C.		**F.**	

12 Do each of the physician owners personally provide clinical services on behalf of this entity? ☐ Yes ☐ No

If no, please explain. _____

_____

13 Are there any owners who are not medical or osteopathic doctors? ☐ Yes ☐ No

If yes, please list their name, professional designation, and percentage of ownership.

Name	Professional Designation	Percentage of Ownership

14 Do you own or operate a separately incorporated optical shop? ☐ Yes ☐ No

If yes, do you maintain separate insurance (general liability with professional liability) for your optical shop? ☐ Yes ☐ No

15 Do you own or operate an outpatient surgical facility (i.e., a surgery center, refractive surgery center, or allow other physicians to use your in-office surgical suite)? ☐ Yes ☐ No

Would you like OMIC to also insure your outpatient surgical facility? ☐ Yes ☐ No

16 Do you own or operate a medical spa? ☐ Yes ☐ No

17 Do you conduct clinical trials? ☐ Yes ☐ No

18 Do you provide audiology services? ☐ Yes ☐ No

19 **A.** Please specify the number of optometrists and advanced practice professionals you employ or contract with: ☐ None

Category	Employed	Contracted	Category	Employed	Contracted
Optometrists (OD)			Nurse Anesthetists (CRNA)		
Physician's Assistants (PA)			Nurse Practitioners (NP)		
Surgical Assistants (SA)					

B. For each employee or contractor noted above, submit a copy of the Declarations page from their current policy.

C. Do any of the optometrists employed by your practice perform any procedures other than epilation (mechanical, electrical, or photo), adult diagnostic canalicular probing or irrigation under topical anesthesia, punctal closure with plugs, removal of superficial foreign bodies from the cornea or conjunctiva, removal of sutures from the lid or adnexa, use of diagnostic lasers (e.g., OCT), and gonioscopy? ☐ Yes ☐ No ☐ N/A—do not employ optometrists

I**f yes,** please list other procedures performed: _____

_____

D. Would you like to insure your employed PA(s), NP(s), SA(s), OD(s), or CRNA(s) as additional insureds under your policy? ☐ Yes ☐ No

20 Please attach a copy of your office letterhead.

21 What form(s) of advertising *(other than a general yellow pages listing)* do you use? Please check all that apply.

☐ None ☐ Mass Mailings ☐ Print ☐ Radio ☐ Television ☐ Billboard

☐ Internet (*provide website address*): _____

Submit copies of all advertising currently used.

22 Has any medical professional liability insurer canceled, declined coverage, refused renewal, or renewed your coverage under restrictive conditions, 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.

23 Has a fee complaint or professional conduct complaint ever been registered against the entity, its physician associates, or 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 operative notes.

24 **A.** Have **any** professional liability or premises liability claims or suits been brought against the entity or its non-physician employees within the past 10 years *(regardless of merit)*? ☐ Yes, Number: _____ ☐ No

B. Are there any other professional liability claims or suits pending against the entity or its non-physician employees? ☐ Yes, Number: _____ ☐ No

C. Within the past 10 years, have you reported any other incidents or potential claims to your present or previous carriers? ☐ Yes, Number: _____ ☐ No

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

If you answered "yes" to any of the above, please complete a **Prior Claims Information Supplement** for each circumstance. For more than one incident or claim, please use photocopies of the form.

E. With your application, please submit a "loss history"/"claims experience" report **provided by your insurance carrier** indicating your reportable claims history.

25 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: _____

26 **Attach a copy of the Declarations Page(s) and all applicable Endorsements from your current policy.**

27 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.)

28 Is your current coverage on a ☐ claims made or ☐ occurrence basis?

If claims made:

A. What is your retroactive date? _____

B. Do you wish to buy prior acts coverage from OMIC to insure you for new, unreported claims arising from services you provided while you were insured with your present carrier? ☐ Yes ☐ No

C. If no, do you intend to purchase extended reporting endorsement ("tail") coverage from your present carrier? ☐ Yes ☐ No

29 Check the limits of liability you would like.

☐ $100,000/$300,000* ☐ $500,000/$1,000,000* ☐ $2,000,000/$4,000,000

☐ $200,000/$600,000* ☐ $500,000/$1,500,000 ☐ $5,000,000/$10,000,000

☐ $250,000/$750,000* ☐ $1,000,000/$3,000,000 ☐ Other (*specify*: _____)

** Available only in states with Patient Compensation Funds*

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? ☐ N/A ☐ 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.

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.

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 *(Do not use signature stamp.)* *Title*

_____ _____

Authorized Representative's Name *(Please print.)* *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 *(Do not use signature stamp.)* *Title*

_____ _____

Authorized Representative's Name *(Please print.)* *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 at 126 College Street, Suite 400, Burlington, Vermont 05401; and the main business office being located at 655 Beach Street, San Francisco, California 94109-1336.

The Applicant hereby acknowledges that:

1. The undersigned professional entity, hereafter referred to as "the Applicant," represents and warrants that the entity is at least 50% owned or controlled by ophthalmologists who are licensed to practice medicine in each state where they practice and who are members of the American Academy of Ophthalmology, or applicants for membership whose membership is thereafter accepted, or their immediate family members.
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 *(Do not use signature stamp.)* *Title*

_____ _____

Authorized Representative's Name *(Please print.)* *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 (Do not use signature stamp.) *Title*

_____ _____

Authorized Representative's Name (Please print.) *Date*