APPLICATION FOR LOCUM TENENS COVERAGE

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

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

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

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

2 Name of the physician for whom you will be working: _____

3 Address at which you will be working: _____

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

Office Phone: _____ Fax: _____ Email address: _____

4 Dates which you will work from: _____ Through and including: _____

5 Date of Birth: _____ 6 Gender: ☐ Male ☐ Female

7 State Medical License Number: _____ State: _____

8 Medical School: _____

Country: _____ Year Graduated: _____ Degree: _____

9 Internship: _____
Hospital *City* *State*

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

10 Residency:

A. _____
Hospital *City* *State*

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

B. _____
Hospital *City* *State*

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

11 Fellowship in: _____
Subspecialty

_____
Hospital *City* *State*

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

12 Board Certification: ☐ ABO ☐ AOBOO ☐ Not ABO or AOBOO certified

13 Number of CME credits completed in the past 12 months: _____

If you answer *"yes"* to any of questions 14 through 20 below, please provide complete details.

14 Within the past 10 years, has any professional liability insurer canceled, declined coverage, non-renewed, or renewed your coverage under restrictive conditions? ☐ Yes ☐ No

If yes, 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 been treated for any such condition? ☐ Yes ☐ No

16 Do you have ***any*** medical condition(s) which might impair your ability to practice ophthalmology? ☐ 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 medical or DEA license, privileges at a medical facility, membership in a medical association, or certification by a medical board within the past 10 years? ☐ Yes ☐ No

19 Has a fee or professional conduct complaint been registered against you within the past 10 years? ☐ Yes ☐ No

20 A. Have any professional liability claims been brought against you within the past 10 years (regardless of merit)?

☐ Yes ☐ No

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

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

21 Does your present insurance carrier extend coverage to you for services you render as a locum tenens? ☐ Yes ☐ No

If yes, please ***submit a copy of your Declarations page.***

Note: If approved, coverage will apply solely to professional services rendered within the scope of your training, licensure, and employment by the insured ophthalmologist listed in question 2 above, and you will share limits of liability with the employing ophthalmologist.

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

_____ _____

Applicant's Signature *Date*

_____

Print Name