OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
A Risk Retention Group

OPTOMETRIST APPLICATION

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GENERAL INFORMATION/COVERAGE

1. Name: _____
   First *Middle* *Last* *Suffix*
2. Date of Birth: _____ Gender: Male Female __ Other
3. Please list the state/s that you currently, or have ever, held an Optometrist License:
   _____
4. Employer: _____
5. Mailing Address_____
   Address State Zip Code County
6. What is your primary City, County and State of Practice? _____
7. What is your requested date of coverage? _____
8. What is your effective date of employment? _____
9. How many hours per week do you practice? _____
10. Please check if you are requesting shared or separate limits of liability: Shared Separate
11. Do you comply with the American Academy of Ophthalmology's Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care? Yes No
12. Do you administer any injections or perform any procedures utilizing lasers (other than diagnostic), injections or scalpels? Yes No
    If yes, please state those procedures below. Please note that coverage may not be available for procedures that utilize such instruments:
    Procedures:
    _____
    _____
13. Do you perform Light Adjustable Lens adjustments post surgery? Yes No
    If Yes, please review OMIC's Underwriting Guidelines – Light Adjustable Lens (LAL). Do you comply with the reviewed guidelines? Yes No
14. In order to be accepted for insurance by OMIC, 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.
    Do you follow these practices? Yes No N/A
15. Do you provide outside services? Yes No N/A
    If yes, please attach a copy of your certificate of insurance.

DISCLOSURES

16. Have you been diagnosed with a substance abuse or mental health disorder within the past 10 years? Yes No
    If yes*, please attach a letter from your treating physician outlining the dates of treatment and current status*.
17. Have you been diagnosed with any medical condition which might impair your ability to practice within the past 10 years? Yes No
    If yes*, attach a letter from your/their treating physician describing the medical condition and outlining the dates of treatment and current status*.

18. 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, within the past 10 years? Yes No
19. 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
20. Has a fee or professional conduct complaint been made against you within the past 10 years? Yes No

If yes to questions 19 or 20, please provide a copy of the complaint, the provider's response, and, if resolved, the final resolution. For professional conduct complaints, also submit copies of the patient charts.

21. Within the past 10 years, has any insurer canceled, declined, non-renewed, or otherwise restricted coverage for you? Yes No

If yes, please provide details on a separate page and submit a copy of any correspondence with the insurance carrier concerning this action.

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

If yes, please state the number of claims: _____

23. Are there any older professional liability claims currently pending against you? Yes No
24. Are you aware of any facts or circumstances that might give rise to a claim, regardless of whether it has been reported to your current or previous carrier? Yes No

If there are any **"yes"** answers for this section, **OMIC will provide a Claims Narrative Addendum for you to complete.**

WARRANTY, ACCEPTANCE OF POLICY TERMS, AND AUTHORIZATION

I understand that all statements made in this application and follow-up communications (e.g., via email), are material to OMIC's decision to issue coverage. I warrant that all information I have provided is true and complete to the best of my knowledge and belief and is given in good faith. If I am not the applicant but am completing the application on the applicant's behalf, by my signature, I represent that the applicant has authorized me (the "authorized representative") to do so and understands and agrees that any representation I make on their behalf is binding upon them.

I agree to promptly update the information in this application if any changes occur while the application is pending or after OMIC extends coverage. I understand that failure to do so may result in declination or termination of coverage, or denial of a claim if the false or undisclosed information is material to the claim. I understand that this application and any other documents submitted to OMIC for coverage, together with the policy, the Declarations, and any endorsements, will constitute the contract of insurance between OMIC and the insureds under the policy. I understand that coverage is not effective until such coverage is approved, the required premium is paid, and Declarations reflecting the changes are issued. I warrant that the applicant has had access to the OMIC policy for review and agrees to be bound by the terms, conditions, exclusions, restrictions, and definitions of the policy.

The applicant consents to the exchange of information and documents between OMIC and any insurance companies, hospitals, teaching institutions, professional associations, licensing agencies, and other individuals or entities that may have information relevant to this application, the applicant's qualifications for insurance, or any claims under review. The applicant fully releases from liability (1) OMIC and its agents and representatives for any actions taken in connection with evaluating this application, the applicant's qualifications for insurance, and any claims under review, and (2) all individuals and organizations who provide information or documents to OMIC or its agents or representatives regarding the same matters.

Signature _____ Title _____

If Signed by Authorized Representative, Name and Title _____ Date _____

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 responsible 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 any award.

CLAIMS MADE AND REPORTED POLICY DISCLOSURE

The insurance policy you are applying for is a claims made and reported policy. It applies only to claims made against the insured 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 insured's retroactive date. A claim is considered made when it is received by the insured and reported when it is received by OMIC. Upon termination of the policy or an insured's coverage under the policy, an extended reporting period endorsement may be available. Carefully review the extended reporting period policy provisions and when you must purchase or accept any offered extended reporting period endorsement.