OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
A Risk Retention Group

PHYSICIAN & ENTITY APPLICATION

Professional and Limited Office Premises Liability Insurance Coverage

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P.O. Box 880610, San Francisco, CA 94188-0610 EMAIL: omic@omic.com WEB: www.omic.com

APPLICATION CHECKLIST

Please submit the following documentation with your completed application to OMIC:

- ✓ A 10-year claims history report
- ✓ A curriculum vitae or credentialing form listing your education and practice history
- ✓ Current Declaration Page or Certificate of Insurance

Complete and attach supplemental application/addendums as required for:

- ✓ Screening or treatment of Retinopathy of Prematurity (ROP)
- ✓ Kentucky applicants

GENERAL INFORMATION

1. Name:_____
   First *Middle* *Last* *Suffix*
   _____
2. Other name(s) under which you currently do business or name(s) used in the past
   _____
3. Authorized Representative for insurance matters Title
   _____ _____
   Email Phone
   _____ _____
4. A. Mailing Address City
   _____ _____
   State Zip Code County
   _____ _____
   B. Billing Address *(if different from above)* City
   _____ _____
   State Zip Code County
5. Date of Birth: _____ Gender: Male Female Other
6. Licensure: A. State _____ License Number _____
   B. State _____ License Number _____

PRACTICE LOCATIONS

Location	Primary	2	3	4	5	6
County						
State						

7. Do you provide services in any country, US territory, or US possession other than the fifty United States and/or District of Columbia? Yes No

REQUESTED COVERAGE INFORMATION

8. What is your requested effective date of coverage?

   _____

   If your current coverage is on a claims-made policy, ***do you wish to buy prior acts coverage*** from OMIC (i.e., coverage for claims arising from services rendered on or after your retroactive date and before your effective date with OMIC that have not been reported to another carrier)? Yes No N/A

   If yes, what is the retroactive date stated on your current declaration or certificate of insurance?

   _____

   If no, do you intend to purchase an extended reporting period endorsement ("tail" coverage) from your current carrier? Yes No N/A

9. Check the limits of liability you are requesting:

   _$100,000/$300,000 (Louisiana only)
   $500,000/$1,500,000
   $1,000,000/$3,000,000
   _$500,000/$1,000,000 (Nebraska only)
   $2,000,000/$4,000,000
   $2,300,000/$6,900,000 (New York only)
   Other (Specify): _____

10. Do you conduct clinical trials? Yes No

    If yes,

    a. What percentage of your practice activities are devoted to clinical trials? _____
    b. Are any of the clinical trials patient-funded? * Yes No
    c. Do any of the clinical trials involve stem cell research? Yes No

    ** A patient-funded trial is one in which participants pay for the study, with no additional funding from sponsors, charities, or insurance.*

11. Do you provide telemedicine services other than video appointments? Yes No
12. On average, how many hours per week do you practice? _____

MEDICAL (MD, DO) & ENTITY COVERAGE

13. What is your primary subspecialty? (see below) _____

    SUBSPECIALTIES: Comprehensive, Anterior Segment, Corneal & External Disease, Glaucoma, Medical Retina, Neuro-Ophthalmology, Ocular Oncology, Oculofacial Plastic Surgery, Ophthalmic Pathology, Optics/Refractive, Pediatric Ophthalmology, Refractive Surgery, Retinal & Vitreal Surgery, Uveitis

14. Please review our Coverage Classifications and select your desired class below:

    No Surgery Surgery Class 1 Surgery Class 2 Surgery Class 3

15. Please review Our Society Partners to see if you qualify for our member discount. If applicable, what society are you currently a member of?

    _____

16. Do you maintain separate insurance for any of your practice activities? Yes No
***If yes**, please provide a certificate of insurance.*

17. Do you provide ROP care to infants when they are less than 55-weeks postmenstrual age (gestational age plus post-natal age)? Yes No
If *yes*, please complete the Supplemental Questionnaire for Retinopathy of Prematurity (ROP) for each physician.

18. Do you perform any procedures not within your ophthalmic residency or fellowship training (non-ophthalmic procedures)? Yes No
If yes, please list the procedure(s) performed:
_____

19. Do you personally obtain the patient's informed consent by discussing the procedure's indication, alternatives, benefits, and risks? Yes No
If no, please explain:
_____

20. Do you comply with the American Academy of Ophthalmology's Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care? Yes No
    a. Do you have a written protocol for co-management? Yes No N/A

21. Do you have a medical entity? Yes No N/A
If yes, please provide the following information:
If you have more than one medical entity, please utilize the chart below on an additional page.

Legal Name of Entity	
Other name(s) under which this entity does business	
Are there any owners who are not ophthalmologists? *If yes*, provide the name and specialty of each non-ophthalmologist owner, and their percentage of ownership.	Name(s): Specialty: Ownership %:
Requested effective date of coverage	
Retroactive Date	
Please check if you would like Shared or Separate limits of liability for your medical entity.	Shared Separate
Practice Type	Single Owner Multi-Owner Multi-specialty

22. What is your role in the practice? Owner Employee Independent Contractor

23. Please list all medical (MD) or osteopathic (DO) physicians from your entity entered above and the status of each using the codes below. Continue on a separate page, if necessary. If any physicians are not insured by OMIC, submit a certificate of insurance from their current policy.
    I am the only MD or DO in my practice.
    Status Codes: O = Owner R= Employer E = Employee I = Independent Contractor

    Name Status

    a. _____ _____
    b. _____ _____
    c. _____ _____

OPTOMETRISTS AND ADVANCED PRACTICE PROFESSIONALS

Not applicable (you do not employ optometrists or advanced practice professionals).

24. Do you employ any optometrists (ODs) in your practice that you would like OMIC to insure? Yes No

If yes, please complete the table below. *If there is more than one, please utilize the chart below on an additional page. Please note that OMIC only insures optometrists who are employees of your practice.*

Name:	
Date of Birth	
Gender:	Male Female Other
License Number & State	License # State:
Primary Location Address	
County & State	County: State:
Retroactive Date:	
Average hours worked per week	

25. If an optometrist or any non-physician administers any injections or performs any procedure utilizing lasers (other than diagnostic), injections or scalpels, please state those procedures below. Please note that coverage may not be available for procedures that utilize such instruments:

    Procedures:
    _____
    _____

26. Do any ODs in your office 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
27. 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 the optometrists who take call in your group, if any, follow these practices? Yes No N/A
28. Optometrists are covered only for direct patient treatment rendered within the scope of their employment by the insured group. In order to be accepted for insurance by OMIC, optometrists must maintain separate coverage for any professional services outside of their employment.
    Do the optometrists in your group who provide outside services, if any, have separate coverage for this?
    Yes No N/A
29. Do you employ any Certified Registered Nurse Anesthetists (CRNAs)? Yes No
    If yes, please complete an application for each CRNA in your practice. *Please note that OMIC only insures CRNAs who are employees of your practice*.

30. Do you employ Physician Assistants, Nurse Practitioners, or other advanced practice providers? Yes No
    If yes, please list any that are a current participant in a patient compensation fund:
    _____

DISCLOSURE QUESTIONS

If you answer "yes" to any questions 30 through 32 please provide details on a separate page. *Questions 30-32 apply to the physician applicant and any optometrists or advance practice professionals seeking coverage with OMIC under this application ("other providers").*

31. Have you or any provider been diagnosed with a substance abuse or mental health disorder within the past 10 years?
    Yes No
    If yes*, please attach a letter from the treating physician outlining the dates of treatment and current status*.
32. Have you or any provider 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 the treating physician describing the medical condition and outlining the dates of treatment and current status*.
33. Have you or any provider 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

34. Has any investigation, disciplinary action, or negative change in status occurred with respect to your license to practice; DEA license; privileges at a medical facility; membership in a medical association; or certification by a board within the past 10 years? Yes No
35. Has a fee or professional conduct complaint been made against you within the past 10 years? Yes No

If yes to question 33 or 34, 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.

36. Within the past 10 years, has any medical professional liability insurer canceled, declined, non-renewed, or otherwise restricted coverage for you or your medical entity(ies), or have you withdrawn your application or has the insurer terminated your coverage due to unfavorable underwriting review? 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.

PREVIOUS INSURANCE

37. List the names of all professional liability insurance carriers that have insured you or your entity(ies) during the past ten years and the dates of such coverage. *Please also provide the requested declarations/certificates of insurance referenced in the Application Checklist.*

	Insured	Carrier	From:	To:
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____

If there are any gaps in coverage please explain the reason(s) why.

_____

CLAIMS INFORMATION

38. Have any professional liability claims been brought against you, your entity(ies), or any optometrists or advance practice professionals seeking coverage with OMIC under this application ("other providers") within the past 10 years (*regardless of merit*)? Yes No

If yes, please state the number of claims: _____

39. Are there any older professional liability claims currently pending against you, your entity(ies) or other providers? Yes No
40. 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, **please complete the Claims Narrative Addendum.**

WARRANTY AND ACCEPTANCE OF POLICY TERMS

I understand that all statements made in this application, including supplemental questionnaires 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. By my signature, I represent that all individuals and entities for whom coverage is sought ("the applicants") have authorized me (the "authorized representative") to complete and submit this application on their behalf. Each applicant 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. (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 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 the policy is not effective until coverage is approved, the required premium is paid, and Declarations are issued.

I warrant that I have reviewed the OMIC policy to understand the rights and duties it imposes and have provided the applicants with access to the policy for their own review. I understand that I should consult legal or insurance professionals regarding insurance coverage. By signing this application as the authorized representative, I warrant that all applicants agree to be bound by the terms, conditions, exclusions, restrictions, and definitions of the OMIC policy.

Signature of Authorized Representative	Title
Authorized Representative's Name and Title	Date

AUTHORIZATION TO RELEASE INFORMATION

By my signature, I represent that all individuals and entities for whom coverage is sought ("the applicants") have authorized me (the "authorized representative") to execute this authorization to release information on their behalf.

I consent 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 applicants' qualifications for insurance, or any claims under review.

I fully release from liability (1) OMIC and its agents and representatives for any actions taken in connection with evaluating this application, the applicants' 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 of Authorized Representative	Title
Authorized Representative's Name and Title	Date

MEMBERSHIP APPLICATION AND AGREEMENT

By my signature, I represent that all physician and professional entity applicants have authorized me (the "authorized representative") to complete and submit this membership application and agreement on their behalf.

For and in consideration of the benefits to be derived therefrom, the physician and professional entity applicants hereby apply for membership in the Ophthalmic Mutual Insurance Company (a Risk Retention Group) ("OMIC"), whose principal office is in the state of Vermont, and whose main business office is located at 655 Beach Street, San Francisco, California 94109.

I hereby represent and warrant that:

1. Each physician applicant is licensed to practice medicine within the state(s) where they conduct their practice.

2. Each professional entity applicant provides predominantly eye care-related health services.

I hereby acknowledge that:

1. Membership is subject to acceptance by OMIC.

2. Membership begins on the original effective date of the policy or the date the member is first added to the policy, whichever is later. Membership ends upon termination of the member's coverage or the whole policy, whichever occurs first. An extended reporting period (tail) endorsement does not extend the membership period. After termination of membership, the former member has no right to participate in any return of premiums or distribution of OMIC's assets upon dissolution, except as provided under separate loan or surplus contribution instruments issued by OMIC.

3. Membership evidences ownership in OMIC to the extent required by Vermont law governing mutual insurance companies and risk retention groups.

I have reviewed the OMIC Bylaws and agree that, if this application for insurance is accepted, the physician and professional entity applicants will become members of OMIC and be bound by the terms and conditions of the OMIC Bylaws as may be amended from time to time.

Signature of Authorized Representative _____ Title _____

Authorized Representative's 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.

CLAIMS NARRATIVE

Please complete one form for each claim or suit. If you require additional space, you may attach an additional page.

1. Applicant Name: _____
2. Name of Patient/Claimant: _____
3. Dates of Treatment: _____
4. Date of Claim/Suit: _____
5. Claimant's Allegation: _____
6. Carrier Providing Defense: _____
7. Status: Claim ¯ Suit (summons and complaint served)
8. Claims Narrative: Please provide a summary of events from your perspective, including the nature of treatment and your involvement. Please include any changes you may have made in your practice as a result of the claim. Kindly provide sufficient details so that OMIC can make an independent assessment of the care rendered.

_____
_____
_____
_____
_____
_____
_____
_____
_____

(Continue on a separate page, if necessary)

9. Disposition of Claim: Open If open, has the carrier indicated a desire to settle? Yes No
   Closed Amount of Settlement/Judgement: $_____
   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 the incident.