APPLICATION FOR OPTOMETRISTS
PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

NOTICE: THE COVERAGE APPLIED FOR PROVIDES CLAIMS-MADE COVERAGE WHICH PROVIDES LIABILITY COVERAGE ONLY IF A CLAIM IS MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

If space is insufficient to answer any question fully, attach a separate sheet.

APPLICANT INFORMATION

1. Applicant (include professional degree if applicant is an individual): _____

   _____

2. Formal business, corporate or partnership name (s) : _____

3. Principal business premise address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   Please attach a list of additional office addresses.

4. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... ☐ Yes ☐ No
   If yes, has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No

APPLICANT PRACTICE

1. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

   _____

2. Please provide revenues for: **Last 12 Months** $_____ **Next 12 Months** $_____

3. Please provide the number of patient or client visits: **Last 12 Months** _____ **Next 12 Months** _____

4. Please specify any professional societies or associations in which you are a member: _____

   _____

5. Are you associated with or do you work for a physician or surgeon? ..... ☐ Yes ☐ No
   If yes, please give the name and the specialty of the physician: _____

6. Do you provide any services at an assisted living facility / nursing home, correctional facility and/or hospital? ☐ Yes ☐ No
   If yes, provide details: _____

PERSONNEL

1. Please list the number and type of staff and/or independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

No.	Type of Profession	No.	Type of Profession	No.	Type of Profession
_____	Opticians	_____	Optometrists	_____	Nurses
_____	Ophthalmologists	_____	Other (specify)_____		

2. Do you supervise any individuals who are not your own employees? ☐ Yes ☐ No.
   If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

APPLICANT AFFILIATIONS

1. Do you own or operate any business other than that shown in Question 1(a) above? ..... ☐ Yes ☐ No
   If yes, please give details on a separate sheet.
2. Are you employed by any individual or entity other than that shown in Question 1(a) above? ..... ☐ Yes ☐ No
   If yes, please attach an explanation describing details of your responsibilities.
3. Are you under contract to any individual or entity other than that shown in Question 1(a) above? ..... ☐ Yes ☐ No
   If yes, please attach an explanation describing details of your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached.
4. Are you employed by or under contract to any government entity? ..... ☐ Yes ☐ No
   If yes, please attach an explanation including the details of your responsibilities.

APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

Have you or any of your employees:

1. Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? ..... ☐ Yes ☐ No
2. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... ☐ Yes ☐ No

Previous Professional Liability Insurance:

Policy Period	Insurer	Indicate whether Claims Made or Occurrence policy	Limits of Liability	Deductible	Retro Date	Premium

3. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ☐ Yes ☐ No
4. Has any claim or suit been brought against you and/or any of your employees? ..... ☐ Yes ☐ No
   If yes, a Supplemental Claim Information Form must be completed for each claim or suit.
5. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? ..... ☐ Yes ☐ No
   If yes, please give details on a separate sheet.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a claim or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or entity(ies) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there be knowledge of any such fact, circumstance or situation, any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a claims made basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the extended reporting period option is exercised in accordance with the terms of the policy. The policy has specific provisions detailing claim reporting requirements.

The underwriting manager, Insurer and/or affiliates thereof are authorized to make any inquiry in connection with this application. Information regarding the applicant, or any person(s) or entity(ies) proposed for this insurance, received, found or developed by us and not part of the application, shall be used solely at our discretion, who shall not have any liability for the use or failure to use such information. Any such independently developed information shall not be attached to any subsequently issued policy or be considered part of the application.

Signing this application does not bind the Insurer to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The underwriting manager, Company and/or affiliates thereof, reserve the right to amend or withdraw terms upon review of the above additional information. In the event of any material change in underwriting information before coverage is bound, terms may be modified or withdrawn.

WARRANTY

I/We warrant to the Insurer, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to the underwriting manager, Insurer and/or affiliates thereof.

The statements in the Declarations are accurate and complete.

That the statements made in the application and attachments and any other materials submitted are true and are the basis of this Coverage Part and are considered as incorporated into and constituting a part of this policy

That the statements made in the application and attachments and any other materials submitted are representations and that such representations are deemed material to the acceptance of the risk or the hazard assumed by us under this Coverage Part and that this Coverage Part is issued in reliance upon the truth of such representations

That in the event that the application, including attachments and any other materials submitted, contains misrepresentations which materially affect either the acceptance of the risk or the hazard assumed by us, this Coverage Part in its entirety shall be void and of no effect

Must be signed within 60 days of the proposed effective date.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.