

INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR OPTOMETRISTS

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| Broker ID # _____ (Internal use only) |
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| Code: 300636w |
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HOW TO APPLY:

1. You may apply on-line at www.proliability.com/coa or complete application below. (Please print or type all information)
2. Visit www.proliability.com for more information and to view available professions for applying online.
3. Note the annual premium below for the policy you selected.
4. Return your completed application, along with your annual premium, to the address provided.
Coverage is effective the date your application is approved and payment is received.

PLEASE CONTACT THE PROGRAM ADMINISTRATOR AT THE TOLL FREE NUMBER PROVIDED SHOULD YOU HAVE ANY QUESTIONS REGARDING THE LIMITS AND/OR OPTIONAL COVERAGES REFLECTED.

RESIDENTS OF CALIFORNIA

NOTE: If you are a business owner and/or have employees or any independent contractors working on your behalf, please do not complete this application and instead visit www.COAMemberInsurance.com or call 800-775-2020 to obtain a "Firm" application.

Section A. APPLICANT INFORMATION (REQUIRED)

| | | | |
|--|----------------------|--|------------|
| First Name | Initial | Last Name | |
| Physical Street Address (Must complete) | City | State | Zip |
| Mailing Address (IF DIFFERENT THAN ABOVE) | City | State | Zip |
| Business Phone # | Fax # | Home Phone # | |
| Date of Birth (MM/DD/YYYY) | Email Address | Effective Date Desired (MM/DD/YYYY) | |

Fully Owned dba or Corporation (If Applicable)

Note: Businesses with employees and/or independent contractors, please visit www.COAMemberInsurance.com to obtain a "Firm" application.

Are you an active member of the California Optometric Association? Yes No

Employed:

- A. You are an employee of an entity and receive IRS tax form W-2 (or an unpaid volunteer). You do not have ownership in an entity that issues your W-2 and/or performs professional services for which coverage is requested.
- B. Your Employer has a professional liability policy that does cover your work.

Self-Employed:

- A. You either practice as an independent Solo Practitioner or as an Independent Contractor for which you receive an IRS tax form 1099 or your Employer pays your premium.
- B. You must select Self-Employed if you work for an Employer that you know at the time of application does not purchase professional liability or their policy does not cover your work. You must also complete questions 2 a & b in Section B.
- C. If you have or plan to hire employees and/or independent contractors and you wish to be insured for their actions, please apply as a firm. Please visit www.COAMemberInsurance.com to obtain a "Firm" application.
- D. If you work both Self Employed and Employed and would like to exclude from your coverage work you perform for **any** employer, please visit www.proliability.com/faq for further information.

Section B. UNDERWRITING QUESTIONS

1. **All Applicants:** Within the last ten (10) years:
For all "Yes" responses, attach an explanation on a separate sheet of paper, preferably on any letterhead you might use.

- a. Have you been the subject of any disciplinary or investigative proceedings (including Medi-Cal billing inquiries) and/or been reprimanded by a governmental or administrative agency, hospital or professional association? Yes No
- b. Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
- c. Have you had practice privileges reduced, suspended OR had a license or certification to practice revoked or denied? Yes No
- d. Has any claim or suit been brought against you or are you aware of any incident that might reasonably be expected to lead to a claim or suit? Yes No
- e. Have you had professional liability coverage refused, renewal denied, and/or cancelled? Yes No
- f. ****Optometrist Only**
 Do you hold a license that allows you to provide laser surgery, including but not limited to laser trabeculoplasty, peripheral iridotomy, iridoplasty and capsulotomy, YAG capsulotomies, LASEK, and laser "only" clear-lens extraction? Yes No

2. **Self-Employed Applicants:** Please answer each question below:

- a. Do you perform any services for or at a correctional facility? Yes No
 If yes, please visit www.proliability.com/faq to download and complete the required Correctional Facility Questionnaire. Your application cannot be processed without this form.
- b. Do you rent, sell, manufacture or distribute products? Yes No

Section C. PROFESSIONAL DESIGNATION

Please select your Designation, and whether Employed or Self-Employed by checking the appropriate boxes below.

Full Time (FT) = 21 + hours/week - Part Time (PT) = 20 hours/week or less

Other limit options may be available upon request, please call 800-775-2020 or email COA.Insurance.service@getamba.com for more information.

OPTOMETRIST

Optometrist **Territory 2** (Other than LA County)

*Eligible for First and Second Year Graduate Rates

| Employed \$1,000,000 / \$3,000,000 | Self-Employed \$1,000,000 / \$3,000,000 |
|--|---|
| <input type="checkbox"/> FT \$426 <input type="checkbox"/> First Year Graduate \$213 <input type="checkbox"/> Second Year Graduate \$320 Date of Graduation _____ | <input type="checkbox"/> FT \$426 <input type="checkbox"/> PT \$320 <input type="checkbox"/> First Year Graduate \$213 <input type="checkbox"/> Second Year Graduate \$320 Date of Graduation _____ |

Optometrist **Territory 3** (LA County)

*Eligible for First and Second Year Graduate Rates

| Employed \$1,000,000 / \$3,000,000 | Self-Employed \$1,000,000 / \$3,000,000 |
|--|---|
| <input type="checkbox"/> FT \$678 <input type="checkbox"/> First Year Graduate \$339 <input type="checkbox"/> Second Year Graduate \$509 Date of Graduation _____ | <input type="checkbox"/> FT \$678 <input type="checkbox"/> PT \$509 <input type="checkbox"/> First Year Graduate \$339 <input type="checkbox"/> Second Year Graduate \$509 Date of Graduation _____ |

Section D. GENERAL LIABILITY

Locations must be owned or leased by the named insured. (Not available for brick and mortar practices.)

Would you like to include the optional General Liability Coverage? Yes No

If "Yes", complete the section below and attach a separate sheet if necessary.

Owned or leased premises

| Address | Own or Lease? |
|---------|---------------|
| 1. | |
| 2. | |
| 3. | |

| Premium for General Liability | \$1,000,000 each incident \$3,000,000 annual aggregate |
|---------------------------------------|---|
| Coverage for 1 st Location | <input type="checkbox"/> \$120 |
| Each Additional Location | <input type="checkbox"/> \$50 |

Section E. ADDITIONAL INSURED

This coverage protects each facility under contract with the insured against claims arising out of the sole negligence of the insured.

It should only be purchased if required by contract.

Would you like to include the optional Additional Insured Coverage? Yes No

If "Yes", complete the section below and attach a separate sheet if necessary.

Name, complete physical address of landlords or entities to be named as additional insureds with coverage type and business relationship for each facility.

| | |
|--|--|
| 1. Name _____ _____ Address _____ City _____ State _____ Zip _____ Business Relationship: _____ | <input type="checkbox"/> Professional Liability ONLY <input type="checkbox"/> General Liability ONLY (GL coverage must be purchased) <input type="checkbox"/> Professional & General Liability (GL coverage must be purchased) |
| 2. Name _____ _____ Address _____ City _____ State _____ Zip _____ Business Relationship: _____ | <input type="checkbox"/> Professional Liability ONLY <input type="checkbox"/> General Liability ONLY (GL coverage must be purchased) <input type="checkbox"/> Professional & General Liability (GL coverage must be purchased) |

| Premium for Additional Insured | \$1,000,000 each incident \$3,000,000 annual aggregate |
|----------------------------------|---|
| Professional Liability Only | <input type="checkbox"/> \$156 |
| General Liability Only | <input type="checkbox"/> \$25 |
| Professional & General Liability | <input type="checkbox"/> \$181 |

Section F. PREMIUM CALCULATIONS

| | |
|--|-----------------|
| Step 1. PREMIUM FROM SECTION C | \$ _____ |
| Step 2. RISK MANAGEMENT CREDIT 10% Participation or attendance at an Insurer approved loss prevention course, loss control, risk management, or legal issues seminar or other educational forum that is practice related. | \$ _____ |
| Step 3. SUBTOTAL Steps 1 and 2 | \$ _____ |
| Step 4: NON-DIRECT PATIENT CARE- Check here to add the endorsement <input type="checkbox"/> This endorsement covers non-direct patient care services provided within your area of specialization as a Legal Consultant, Case Management, Expert Witness, Educational Services, Life Care Planning, Utilization Review, and Medical Administration. These services may not be covered under the policy without this endorsement. For more information visit www.proliability.com/faq . | \$ <u>25.00</u> |
| Step 5. OPTIONAL COVERAGES (Section D and E IF APPLICABLE) | \$ _____ |
| Step 6. SUBTOTAL from Step 3 plus Steps 4 & 5 | \$ _____ |
| Step 7. PLUS RISK PURCHASING GROUP MEMBERSHIP FEE "Risk Purchasing Group (RPG) membership fees are used to pay for expenses related to the management and administration of the RPG, including but not limited to RPG state filings and registrations, as well as the creation of risk management and risk avoidance education materials provided to RPG members. The RPG has entered into an administrative services agreement with an affiliated entity, Association Member Benefits Advisors ("AMBA"), for the management and administration of the RPG, and the RPG fees will be used to pay AMBA for the administrative services it provides to and on behalf of the RPG. Please note that the RPG membership fee is subject to change based on the effective date of your policy." | \$ <u>2.00</u> |
| Step 8. SUBTOTAL PREMIUM | \$ _____ |
| Step 9. TOTAL DUE (ROUND TO NEAREST WHOLE DOLLAR) | \$ _____ |

I understand that I am not covered by this insurance for rendering or failure to render any professional services as a physician, surgeon, dentist, nurse midwife, perfusionist, cytotechnologist, chiropractor, podiatrist, osteopath or psychiatrist. I understand that these professional occupations are excluded from coverage. I understand that this insurance will not apply to any proprietor, owner, partner, manager, superintendent, or officer of any hospital, sanitarium, medical clinic, health maintenance organization, managed care facility, foster care agency, adoption agency, or any other facility not specified in the Declarations of the insurance policy. The insurance described herein is subject to the terms, conditions and exclusions of the insurance policy. This insurance is excess when other insurance applies to a loss.

In order to enhance the stability of this professional liability insurance program, coverage has been organized through a purchasing group, pursuant to legislation, known as the Federal Liability Risk Retention Act of 1986, enacted by Congress. Coverage is provided to the purchasing group by Liberty Insurance Underwriters Inc. ("Insurer"). This application is subject to the Insurer's underwriting rules and approval. Your completion of this application and premium payment does not bind coverage or obligate the Insurer to issue you insurance coverage. Coverage will become effective following the receipt of your acceptable application and premium payment. Your application cannot be processed unless it is completed in its entirety.

Once the completed application has been approved and the premium has been received, you will automatically become a member of a risk purchasing group operated by AMBA that is consistent with your professional designation.

INSURANCE FRAUD WARNINGS

IN ALL STATES OTHER THAN THOSE LISTED BELOW: 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 may be a crime and may subject the person to criminal and civil penalties.

ARKANSAS, LOUISIANA, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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 such person to criminal and civil penalties.

