Liberty International Underwriters

300636w

Professional Liability Insurance Application for Optometric Practices/Groups

For the purposes of this application and answering the following questions, the terms 'business' and 'entity' refer to your entire operation including all business owners, partners, officers, employees, independent contractors and volunteers.

1. APPLICANT INFORMATION

Practice Name (include any doing business as names)_____

_____

Physical Mailing Address (P/O. Boxes are not acceptable.)

_____

City State Zip

Are all services provided from this location? ☐ Yes ☐ No

If "No," please provide additional locations: _____

_____

Phone: _____ Fax:_____

Website: _____ E-mail:_____

Contact Name:_____ Title: _____

Contact Phone Number:_____ Date Established:_____ FEIN/Tax ID#:_____

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

Business is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corporation
☐ Professional Association ☐ Other: _____

Please provide all Names and addresses of business owners: _____

_____

Please describe the ownership structure of your business (i.e. Owned 75% by Jane Doe, 25% by John Doe):

_____

_____

2. PERSONNEL SECTION

A. OWNERS:

Name	Professional Occupation	List All Specialties/Licensures/ Certifications	Hours Worked Per Week
1			
2.			
3.			
4.			
5.			
6.			

B. EMPLOYEES/INDEPENDENT CONTRACTORS:
Designation Codes*: E-Employee IC-Independent Contractor

NAME	*Employment Status	PROFESSIONAL OCCUPATION (Include any specialty/licensure/certification if applicable)	HOURS WORKED PER WEEK
1.			
2.			
3.			
4.			

3. EXPOSURE INFORMATION

A. Please describe the professional services provided by your entity:_____

B. Please provide the annual gross revenue and patient visits for your entity. Gross revenue is inclusive of all compensation for the delivery of professional services before expenses, taxes, or other business costs are deducted. Number of patient visits is determined by the number of encounters for which professional services are rendered to an individual.

Gross revenue for the prior 12 months: $_____ Projected gross revenue for the upcoming 12 months: $_____

Number of patient visits for the prior 12 months: _____ Projected number of patient visits for the upcoming 12 months: _____

C. Practice Settings: Please provide the percentage of your entity's work performed at each of the following settings (**total of all percentages must equal 100%).** Additionally, please describe your entities relationship with the facility type. (For example, if you own or operate a clinic place the letter "O" in the box to the left of "Clinic". If you own one clinic and have a contract with another, place "O" and "C" in the box to the left.)

Owned/ Operating (O) Contracted (C)	Type of Facility	Average Time/Week	Owned/ Operating (O) Contracted (C)	Type of Facility	Average Time/Week
	Optometric Office	%		Mobile Unit	%
	Outpatient Surgical/Office Center	%		Nursing Home	%
	Correctional Facility	%		Overnight Care Facility	%
	Educational Institution	%		Staffing Agency	%
	Long Term Care	%			
	Other Miscellaneous Facility (Please Describe) _____				%

D. Do you work in a facility considered retail, big box, such as a Wal-Mart, etc.? ☐ Yes ☐ No
If "Yes", please provide location(s) _____

E. Is your entity affiliated (on staff, on call, on a consulting basis, etc.) with an Ophthalmologist and/or any other Physician? ☐ Yes ☐ No
If "Yes", please provide details including physician name and role/responsibilities (whether the physician sees patients, reviews chart audits, interprets lab results, etc.):

_____

_____

Please provide proof the physician carries professional liability insurance
** No coverage is provided to physicians*

F. Does anyone providing services on behalf of the entity hold licenses that allow them 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
If "Yes," please provide the following details:

a. What percentage of total revenue received are derived from laser surgery?_____%

b. Locations where the laser surgery is being performed:_____

c. List all types of laser surgery being provided:_____

_____

G. Do you perform pre and post operative Lasik care? ☐ Yes ☐ No

H. Do any of your entities employed or contracted staff provide any services as an attorney, accountant or financial planner? ☐ Yes ☐ No
If "Yes", please attach a detailed description.

I. Do any of your entities employed or contracted staff provide any Case Management Services, Consulting Services, Educational Services, Life Care Planning, or Utilization Review? ☐ Yes ☐ No

If "Yes," please provide the number of owners, employed or contracted staff engage in these services:_____

J. Are all professionals in your entity properly licensed and/or certified by your state? ☐ Yes ☐ No ☐ Not required by state

If no, please explain_____

4. RISK MANAGEMENT / LOSS CONTROL

A. Is your entity accredited by a national healthcare accreditation organization (i.e.: AAAHC, JCAHO, NCQA, etc.)? ☐ Yes ☐ No

If "Yes," please specify:_____

B. Please list any risk management certifications held by any owners, partners, officers or employees. If not applicable mark NA: ☐ N/A

_____

_____

Do at least 50% of the entity's owners, partners, officers and employees hold the certifications referenced above? ☐ Yes ☐ No

C. Is there a formal referral process in place for those patients who require additional clinical assessment, diagnosis and/or treatment? ☐ Yes ☐ No

D. Does your entity have the following procedures in place?

1. A formalized risk management program? ☐ Yes ☐ No
2. A formalized program for protection of patient information/HIPAA compliance? ☐ Yes ☐ No ☐ N/A
3. Background checks on all employees and independent contractors prior to hiring? ☐ Yes ☐ No ☐ N/A
4. A formalized CMS compliance program in place? ☐ Yes ☐ No ☐ N/A

E. Does your entity use equipment in the performance of your professional services? ☐ Yes ☐ No
If "Yes," does your entity have a formal medical equipment maintenance program in place that includes the following?

1. Proper training of all equipment users? ☐ Yes ☐ No ☐ N/A
2. Controls over staff owned equipment? ☐ Yes ☐ No ☐ N/A
3. Repairs by qualified personnel? ☐ Yes ☐ No ☐ N/A
4. Policies and procedures for borrowing, lending, selling or donating equipment? ☐ Yes ☐ No ☐ N/A
5. Documentation of all maintenance activities (preventative maintenance, repairs, education)? ☐ Yes ☐ No ☐ N/A

5. CLAIMS & DISCIPLINARY ACTIONS

A. Within the last ten (10) years has your entity or anyone affiliated with your entity:

1. Been the subject of disciplinary or investigative proceedings and/or been reprimanded by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No
2. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
3. Had any state professional license or license to prescribe or dispense narcotics refused, reduced? Suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered? ☐ Yes ☐ No
4. Had privileges reduced, suspended or revoked? ☐ Yes ☐ No
5. Been denied a license or certification to practice? ☐ Yes ☐ No
6. Had Medicare or Medicaid authorities initiate an investigation into alleged billing fraud and abuse directed at you or any employee? ☐ Yes ☐ No

If "Yes" to any of the above questions, please explain in full detail by attachment.

B. Does your entity verify pending license suspensions, revocations or pending disciplinary actions involving current/future employees or independent contractors? ☐ Yes ☐ No

C. Within the last ten (10) years, has a claim or suit been brought against your entity or anyone affiliated with your entity, or are you aware, after inquiry of anyone to whom this insurance is intended to apply, of any incident that might reasonably be expected to lead to a claim or suit? ☐ Yes ☐ No
If "Yes", please visit www.proliability.com/faq to complete the Claim Supplemental Questionnaire for each claim and/or incident.

D. Within the last ten (10) years has your entity or anyone affiliated with your entity had professional liability coverage refused, renewal denied and/or cancelled? ☐ Yes ☐ No
If "Yes", please provide copy of the notice of declination, non-renewal or cancellation.

6. PRIOR INSURANCE

No Prior Acts Coverage Available

Insurance Carrier	Limits	Effective Date	Annual Premium	Claims Made** or Occurrence	Retro –Active Date

7. ADDITIONAL COVERAGE REQUESTED*

*** Subject to additional premium charge**
For more information on General Liability and Additional Insureds, please visit www.proliability.com/faq

☐ **General Liability**: **Property Locations must be owned or leased by the named insured.** (Coverage is not available for brick and mortar pharmacies.)

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

Address	Own or Lease?
1.	
2.	
3.	

☐ **Additional Insured**

This optional 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.
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:	☐ Professional Liability ONLY ☐ General Liability ONLY (GL coverage must be purchased) ☐ BOTH Professional and General Liability (GL coverage must be purchased)
Address:	
City: State: Zip:	
Business Relationship:	

2. Name:	☐ Professional Liability ONLY ☐ General Liability ONLY (GL coverage must be purchased) ☐ BOTH Professional and General Liability (GL coverage must be purchased)
Address:	
City: State: Zip:	
Business Relationship:	

8. Please read carefully and sign and date where indicated on the last page.

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 does not bind coverage or obligate the Insurer to issue you insurance coverage. 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.

YOU MUST SIGN AND DATE THIS APPLICATION

Declaration and Signature -

The undersigned, on behalf of all prospective insureds, after a reasonable inquiry, declares to the best of his/her knowledge and belief that the statements contained herein are true and are the basis of the acceptance of the risk or the hazard assumed by the Insurer under this Policy. It is further agreed by the undersigned, its Subsidiaries and their directors, officers and trustees that the Policy, if issued, is in reliance upon the truth of such representations. It is agreed that, although the signing of the Application does not commit the undersigned to purchase the insurance being applied for, the statements made in this Application shall become the basis of the Policy should one be purchased. The Insurer is hereby authorized to make any investigation and inquiry in connection with this Application deemed necessary.

_____ _____ _____/ _____/ ____

Signature of Authorized Partner / Officer/Owner **Title** **Date**

_____

Name of individual signing this application (printed)

Section Below For Producer/Agency Information Only

_____ _____ _____/ _____/ _____

Producer's Signature **Producer's License Number** **Date**

_____

Producer's Name

☐ **If you are interested in learning more about other lines of coverage that may be available to you through the program administrator (i.e. Business Owners Package, Workers' Compensation, Medical, etc.) please check the box or call the program administrator at 800-775-2020.**

Premiums will be calculated by the Client Advisor. Minimum premium of $300.

Program Administered by:
Association Member Benefits & Insurance Agency
P.O. Box 78001
Minneapolis, MN 55480

www.COAMemberInsurance.com

CA Insurance License #0I96562

Underwritten by: Liberty Insurance Underwriters Inc.