



Optometrist Professional Liability Application – California

3-062w

How to apply: Simply complete the application, enclose your premium check made payable to Marsh and mail to the address provided on page 3. All coverages elected must be under the same plan limits. All premiums are annual. Coverage is effective the date your application is approved and payment is received. Please allow three to four weeks for delivery of your Policy. **Please print neatly or type all information.**

I. APPLICANT

ALL APPLICANTS MUST COMPLETE

NAME _____

DATE OF BIRTH _____

BUSINESS/CORPORATE NAME/DBA (if applicable) (complete ONLY if you own the business) _____ FEDERAL TAX I.D. # _____

NAMES OF OWNERS, PARTNERS AND CORPORATE OFFICERS WHO ARE ACTIVE IN THE BUSINESS, AND THEIR PROFESSIONAL OCCUPATIONS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____

DAYTIME PHONE _____ E-MAIL ADDRESS _____ FAX NUMBER _____

See page 2 of application for premium rates by territory. Full-Time means 20 or more hours per week. Part-Time means less than 20 hours per week.

2. EMPLOYED INDIVIDUALS

Please complete this section if you are not an individual who has employees or independent contractors working on your behalf.

ANNUAL LIMITS AND PREMIUMS

\$2 million per incident/occurrence \$1 million per incident/occurrence
\$4 million annual aggregate \$3 million annual aggregate

Optometrist Full-Time Rate \$ _____ \$ _____
Optometrist Part-Time Rate \$ _____ \$ _____
Optometrist 1st-Year Graduate Rate \$ _____ \$ _____

Employed Individuals Proceed to Section 5

3. SELF-EMPLOYED INDIVIDUALS AND BUSINESS APPLICANTS

Please complete this section if you are a professional who functions on a full- or part-time basis as an independent contractor, or as the owner of a business paid on a fee-for-service basis.

ANNUAL LIMITS AND PREMIUMS

\$2 million per incident/occurrence \$1 million per incident/occurrence
\$4 million annual aggregate \$3 million annual aggregate

You must pay a premium for each optometrist owner within your firm.

of optometrist(s) X rate = premium due
Optometrist owner(s) Full-Time Rate ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____
Optometrist owner(s) Part-Time Rate ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____
Optometrist owner(s) 1st-Year Graduate (Individuals Only) ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____
Other _____ ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____
(Please specify and contact the administrator for appropriate premium.)

You must pay a premium for each employee within your firm.

(use rates from page 2)

Optometrist employee(s) Full-Time Rate ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____
Optometrist employee(s) Part-Time Rate ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____
Optometrist employee(s) 1st-Year Graduate Rate ____ X \$ ____ = \$ ____ ____ X \$ ____ = \$ ____

ALL APPLICANTS MUST COMPLETE AND SIGN PAGE 3 OF THE APPLICATION

4. OPTIONAL COVERAGE SELF-EMPLOYED INDIVIDUALS AND BUSINESS APPLICANTS

ANNUAL LIMITS AND PREMIUMS

\$2,000,000 per incident/occurrence
\$4,000,000 annual aggregate

\$1,000,000 per incident/occurrence
\$3,000,000 annual aggregate

Additional Insured: Premium is for each facility under contract. (List name and address of each facility on a separate sheet of letterhead that you maintain contact with that requires they be added as an additional insured on your Insurance Policy.)

Include only those facilities that insist on this requirement. Premium will be charged for each facility under contract for which coverage is requested.

_____ X \$ 183 = \$ _____

_____ X \$ 156 = \$ _____

General Liability (Not available if you own an Optometry Store)

_____ X \$ 140 = \$ _____

_____ X \$ 120 = \$ _____

Each additional location (On a separate sheet of letterhead, list name and address of each location.)

() X \$ 59 = \$ _____

() X \$ 50 = \$ _____

5. PREMIUM CREDITS

This premium credit is based upon the size of group at the time coverage is purchased. Credits apply as follows: Groups of 2–9 professionals, 4%; Groups of 10–14 professionals, 8%; Groups of 15 or more professionals, 12%.

Subtotal Premium (sections 3 & 4):	\$ _____	\$ _____
Less Size of Group Credit (if applicable):	\$ _____	\$ _____
TOTAL PREMIUM DUE (round to nearest dollar):	\$ _____	\$ _____

6. ALL APPLICANTS MUST ANSWER UNDERWRITING QUESTIONS

1) Have you or any of your employees ever had the following: revoked, suspended, refused, denied renewal, placed on probation, cancelled, or voluntarily surrendered by you or any of your employees or is such an action pending?
(If "YES," please explain on a sheet of your letterhead. Include dates, allegations and amounts.)

State License or Certification..... YES NO

Malpractice Insurance..... YES NO

2) Has any claim or suit ever been brought against you or any of your employees or are you or any of your employees aware of any incident that might reasonably lead to a claim or suit? YES NO
(If "YES," please explain on a sheet of your letterhead. Include dates, allegations and amounts.)

How to Determine Your Professional Liability Premium Rate:

First determine your territory using the territory information below. Next, find the corresponding premium rate for your desired limits of liability from the charts on the right. All coverages must be written with the same limits of liability. Self-employed applicants have the option of purchasing additional insured coverage. Transfer the appropriate rate(s) to page 1 of this application, multiply by the number of optometrists and apply the appropriate *Size of Group Premium Credit* (if applicable).

NOTE: Rates are the same for employed and self-employed optometrists. Rates differ by the number of hours worked per week: 20+ hours per week denotes Full-Time, less than 20 hours per week is considered Part-Time.

TERRITORY 1	TERRITORY 1 LIMITS & ANNUAL PREMIUM RATES	
California (excluding LA County)	\$2 million per incident/occurrence \$4 million annual aggregate	\$1 million per incident/occurrence \$3 million annual aggregate
	Full-Time \$498 per optometrist Part-Time or 1st-Year Graduate optometrist \$374	Full-Time \$426 per optometrist Part-Time or 1st-Year Graduate optometrist \$320

TERRITORY 2	TERRITORY 2 LIMITS & ANNUAL PREMIUM RATES	
California (LA County)	\$2 million per incident/occurrence \$4 million annual aggregate	\$1 million per incident/occurrence \$3 million annual aggregate
	Full-Time \$793 per optometrist Part-Time or 1st-Year Graduate optometrist \$595	Full-Time \$678 per optometrist Part-Time or 1st-Year Graduate optometrist \$509

ALL APPLICANTS MUST COMPLETE AND SIGN PAGE 3 OF THE APPLICATION

I understand that I am not covered by this insurance if I render or fail to render any professional services as any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, nurse anesthetist, cytotechnologist, perfusionist or psychiatrist. I understand that this insurance will not apply to any partner, principal or owner of a residential/overnight facility. 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. Once the completed application has been approved and the premium has been received, you will automatically become a member of the Allied Health Purchasing Group Association, located and domiciled in Illinois, and obtain the insurance coverage afforded through the group policy on an annual term.

This application is subject to the underwriter's approval. Your completion of this application and premium payment does not bind coverage or obligate the insurance company 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. The application is subject to the company's underwriting rules.

Marsh/Seabury & Smith Insurance Program Management receives compensation for services to provide this program; these services may include enrollments, ongoing servicing, billing, marketing, brokerage, customer administrative & claim servicing and communications. Refer to <https://www.personal-plans.com/disclosure> and enter in the security code o3975180 or call us at 1-888-206-5088 for specific details.

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 Company 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 Company is hereby authorized to make investigation and inquire in connection with this Application deemed necessary. 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.

YOU MUST SIGN AND DATE THIS APPLICATION

Signature **X** _____ Date **X** _____

Enclosed is my check for \$ _____ Effective Date Desired* _____

*May not be earlier than the date the administrator receives and approves this application.

I authorize Seabury & Smith/Marsh to charge my: VISA MasterCard Amount \$ _____

Credit Card Number _____ Expiration Date _____

Print name exactly how it appears on card _____

Make check payable to Marsh and return with this application to the address shown below.

Administrator:

MARSH

 MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Seabury & Smith Insurance Program Management
777 South Figueroa Street
Los Angeles, CA 90017
800-775-2020 • COA.Insurance@marsh.com
www.MarshAffinity.com
CA Ins. Lic. #0633005 • AR Ins. Lic. #245544
d/b/a in CA Seabury & Smith Insurance Program Management

Underwritten by:

Liberty Insurance Underwriters Inc., a member of Liberty Mutual Group.

NOTE: This is only a summary of the Insurance Policy provisions. If any conflict exists with the actual Insurance Policy, the terms of the Insurance Policy control.