



Optometrist Professional Liability Application – California

How to apply: Simply complete the application, enclose your premium check made payable to Marsh and mail to the address provided. 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 _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____

DAYTIME PHONE _____ EMAIL ADDRESS _____ FAX NUMBER _____

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

If you have employees or independent contractors, you must complete this section. Full-Time is more than 20 hours per week. Part-Time is 20 hours or less per week.

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 reverse side)

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 \$ _____ = \$ _____

4. OPTIONAL COVERAGE SELF-EMPLOYED INDIVIDUALS AND BUSINESS APPLICANTS

ANNUAL LIMITS AND PREMIUMS

\$2,000,000 per incident/occurrence \$1,000,000 per incident/occurrence
 \$4,000,000 annual aggregate \$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 = \$ _____
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General Liability (Not available if you own an Optometry Store)

_____ X \$ 140 = \$ _____	_____ X \$ 120 = \$ _____
() X \$ 59 = \$ _____	() X \$ 50 = \$ _____

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

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):	\$ _____	\$ _____

ALL APPLICANTS MUST COMPLETE AND SIGN THE BACK OF THE APPLICATION

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?

(If "YES," please explain on a sheet of your letterhead. Include dates, allegations and amounts.)

YES NO

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 the front 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: more than 20 hours per week denotes Full-Time, 20 hours per week or less 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

I understand that I am not covered by this insurance for rendering or failure to render any professional services as the following: physician, surgeon, dentist, nurse midwife, nurse anesthetist, 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 partner, principal or owner of a residential/overnight facility.

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.

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 inquiry 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.

(ALL STATES EXCEPT AR, CO, DC, FL, HI, KY, LA, ME, MD, NJ, NM, NY, OH, OK, PA, TN, VA, WA, WV): 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.

MARSH

Attn: Association Department

777 South Figueroa Street, Los Angeles, CA 90017

d/b/a in CA Seabury & Smith Insurance Program Management • CA Ins. Lic. #0633005 • AR Ins. Lic. #245544

800-775-2020 • www.MarshAffinity.com • COA.Insurance@marsh.com

Underwritten by:

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

55 Water Street

New York, New York 10041

May not be available in all states.

Pending underwriter approval.

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.



Optometrist Professional Liability Supplemental Application – California

How to apply: Simply complete the application **AND THIS SUPPLEMENTAL APPLICATION**, enclose your premium check made payable to Marsh and mail to the address provided. 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.**

APPLICANT

ALL APPLICANTS MUST COMPLETE

Member Non-Member

NAME

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

Business Type: Individual Corporation Partnership Joint Venture Other: _____

YOU MUST SIGN AND DATE THIS APPLICATION

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

ALL APPLICANTS MUST COMPLETE AND SIGN THIS SUPPLEMENT

About Our Role and Compensation

The California Optometric Association has selected Liberty Insurance Underwriters (“Insurer”) for this insurance program. Comparable insurance products may be available in the insurance marketplace. Marsh/Seabury & Smith Insurance Program Management is only offering COA’s selected insurer quote proposal. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to <https://www.personal-plans.com/disclosure> and entering the security code O3975180 or call us at 1-888-206-5088 for specific details.



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

Underwritten by:
Liberty Insurance Underwriters Inc.,
a Member of Liberty Mutual Group.

55 Water Street
New York, New York 10041
May not be available in all states.
Pending underwriter approval.