



California Optometric Association

Optometrist Professional Liability Application

3-962W

Professional Liability Insurance Application

How to enroll: Simply complete all sections of the application form, enclose your premium check made payable to Marsh, and mail to the address provided on the back of this application. All premiums are annual. Coverage is effective the date your application and payment are received and approved in our office. Please allow three to four weeks for delivery of your certificate. **Please print or type all information. If you need assistance completing this application, call us at 800-775-2020.**

1. Applicant

LAST NAME	FIRST NAME	INITIAL	MEMBERSHIP # OR LICENSE #
BUSINESS/CORPORATE NAME/DBA/YOUR NAME IF APPLICABLE		FEDERAL TAX I.D. # OR SOCIAL SECURITY #	
ADDRESS		DAYTIME PHONE	
CITY, STATE, ZIP	COUNTY	FAX NUMBER	
EMAIL ADDRESS			

NAMES OF OWNERS, PARTNERS AND CORPORATE OFFICERS WHO ARE ACTIVE IN THE BUSINESS, THEIR PROFESSIONAL OCCUPATION AND THEIR SOCIAL SECURITY NUMBERS.

Check all that apply:

Self-Employed
 Employee Optometrist
 Independent Contractor
 First Year Graduate _____
DATE OF GRADUATION

Business Type: Individual
 Corporation
 Partnership
 Joint Venture
 Other _____

If you are an Employee Optometrist, list name of Employer: _____

2. Professional Liability

Per Incident
 \$1,000,000
 \$2,000,000
Annual Aggregate
\$3,000,000
\$4,000,000

Self Employed/Employed Optometrist		
<ul style="list-style-type: none"> • Los Angeles County Full Time (Working more than 20 hours per week) Part Time (Working 20 hours or less per week), or First Year Graduate 	# _____ x \$678 = \$ _____ # _____ x \$509 = \$ _____	# _____ x \$793 = \$ _____ # _____ x \$595 = \$ _____
Self Employed/Employed Optometrist		
<ul style="list-style-type: none"> • Rest of California Full Time (Working more than 20 hours per week) Part Time (Working 20 hours or less per week), or First Year Graduate 	# _____ x \$426 = \$ _____ # _____ x \$320 = \$ _____	# _____ x \$498 = \$ _____ # _____ x \$374 = \$ _____
Employees – Must purchase for each Employee Optometrist (Use above premiums)	# _____ x \$ _____ = \$ _____	# _____ x \$ _____ = \$ _____
Please Utilize This Row to Add the Total Number of Optometrists in Your Office:	# _____	# _____
Additional Insured Coverage (Only if Self-Employed and Applicable) – (e.g. State Agency, Dept. Store, etc.) <i>List each entity to be named on a separate sheet of letterhead.</i>	# _____ x \$156 = \$ _____	# _____ x \$183 = \$ _____
Total Premium:	\$ _____	\$ _____
Subtract Size of Group Discount for Total Optometrists in Group: 2 to 9 = 4% 10 to 14 = 8% 15 or more = 12%	- \$ _____	- \$ _____
Premium Due: <i>(Round to the nearest whole dollar)</i>	\$ _____	\$ _____

All applications *MUST* complete and sign the back of the application.

3. Underwriting Questions (Required)

1) Have any of the following ever been revoked, suspended, refused, denied renewal, placed on probation, cancelled or voluntarily surrendered by you or any of your employees? (If "Yes", explain on a separate sheet of your letterhead and attach to the application.)

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", explain on a separate sheet of your letterhead. Please include dates, allegations and amounts.)

4. Provider Contracts

Please list the providers with whom you may currently have a contract:

Vision Service Plan Block Vision Other: _____

AVP Medical Eye Services (MES) Other: _____

Cole Vision Other: _____

Davis Vision Other: _____

I understand that I am not covered by this insurance if I am any of the following: physician (except for optometric physicians), surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, cytotechnologist, electroneurodiagnostic technologist, perfusionist, 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. The insurance described herein is subject to the terms, conditions and exclusions of the insurance certificate. 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 the Chicago Insurance Company, a member company of The Fireman's Fund Insurance Companies. 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.

I declare the information contained in the application is true and that no material facts have been suppressed or misstated. I understand that incorrect information could void protection. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Signature **X** _____

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

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

Make check payable to: **Marsh**. Return your check and this application in the envelope provided.

Or pay by credit card: I authorize Marsh to charge my: Visa MasterCard Amount: \$ _____

Credit Card Number: _____ Expiration Date: _____

Print name exactly as it appears on card: _____

Mail To: Marsh, attn: Association Department, 777 South Figueroa Street, Los Angeles, CA 90017

Administered by:

Marsh

3-962 (4/09) ©Seabury & Smith Insurance Program Management 2009
d/b/a in CA Seabury & Smith Insurance Program Management
CA License #0633005 • 777 S. Figueroa St., Los Angeles, CA 90017
800-775-2020 • COA.Insurance@marsh.com • www.MarshAffinity.com

Underwritten by:

Chicago Insurance Company

a member company of The Fireman's Fund Insurance Companies.
Rated "A" (Excellent) by the independent A.M. Best Company.

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 the security code O3975180 or call us at 1-888-206-5088 for specific details.

Marsh is part of the family of MMC companies, including Kroll, Guy Carpenter, Mercer, and the Oliver Wyman Group (including Lippincott and NERA Economic Consulting).