



# Optometrists Professional Liability Insurance Application

(Claims Made Basis)

Please mail or fax this completed application to:

Rockwood Programs, Inc., 4001 Miller Road, Wilmington, DE 19802-1999

Toll-Free: (800) 558-8808 • Fax: (302) 765-6039 • Email: www.rockwoodinsurance.com

1. Applicant name:

Principal business address:

Telephone number:

2. Date established (if applicant is a facility/entity):

3. Date of birth (if applicant is an individual):

4. Applicant's practice is a:

- |  |   |
|--|---|
| <input type="checkbox"/> Solo practitioner (unincorporated)                  | <input type="checkbox"/> Solo practitioner (incorporated) |
| <input type="checkbox"/> Corporation (for-profit)                            | <input type="checkbox"/> Corporation (non-profit)         |
| <input type="checkbox"/> Partnership   | <input type="checkbox"/> Professional Association         |
| <input type="checkbox"/> Individual, employee of (provide name of employer): |   |

5. Please describe in detail the nature of the applicant's operation and types of services rendered:

6. Please state sources and amounts of total revenue:

	last 12 months	next 12 months
Charitable contributions		
Government funding		
Fee for services		
Other – specify:		
<b>Total gross revenue:</b>		

7. Please indicate the number of:

a. patient encounters in the last 12 months:

(patient encounters refers to number of visits - not number of patients)

b. patient tests carried out in the last 12 months:

8. Please indicate the number of:

a. estimated patient encounters in the next 12 months:

b. estimated patient tests carried out in the next 12 months:

9. a. If applicant has a training school, complete the following:

Profession for which students are being trained	Max no. of students per session	Number of sessions per year	Number of faculty per session	Qualification of faculty (e.g. MD RN)



iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?

Yes  No

If Yes to any of the above, please attach an explanation.

11. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others?

Yes  No

If Yes, please attach a detailed explanation.

12. Does the applicant (wholly or in part) operate or administer any hospital, nursing home or other institution where medical services are customarily rendered?

Yes  No

If Yes, please give details, including name, location, size and number of beds:

13. a. List prior professional liability insurers for the past five years (if none, please tick box)

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

14. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage?

Yes  No

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

15. Has any similar insurance ever been declined or cancelled? Yes  No

If Yes, please attach an explanation.

16. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes  No

If Yes, please attach complete details including a description of the incident(s).

17. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes  No

If Yes, please complete a supplemental claims information form for each claim.

How many claims have been made in the last three (3) years?

18. Are you associated with or do you work for a physician or surgeon? Yes  No

If Yes, explain and provide name & specialty of the physicians.

19. Are any laser/lasik procedures performed by or on behalf of you? Yes  No

If Yes, please explain.

It is understood and agreed that this application shall become part of the application for Professional Liability Errors and Omissions Insurance.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Date:

**A copy of this application should be retained for your records.**