AOA Professional Advantage
Professional Liability | Business Owner's Package

Optometrist Professional Liability Application – New York

S.C. ___W___

How to apply: Simply complete the application, enclose your premium check made payable to Seabury & Smith 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 certificate. **Please print neatly or type all information.**

1. APPLICANT

ALL APPLICANTS MUST COMPLETE

LAST NAME | FIRST NAME | MIDDLE INITIAL | MEMBER I.D. #

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

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

ADDRESS | DAYTIME PHONE | E-MAIL ADDRESS

CITY, STATE, ZIP | COUNTY | FAX NUMBER

2. EMPLOYED INDIVIDUALS

See back 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.**

ANNUAL LIMITS AND PREMIUMS

	$2,000,000 per incident $4,000,000 annual aggregate	$1,000,000 per incident $3,000,000 annual aggregate
Optometrist Full-Time Rate	$ _____	$ _____
Optometrist Part-Time Rate	$ _____	$ _____
Optometrist 1st Year Graduate Rate	$ _____	$ _____

Employed Individuals proceed to Section 6

3. SELF-EMPLOYED INDIVIDUALS AND BUSINESS APPLICANTS

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 _____ (Please specify and call administrator for rate.)	____ X $ ____ = $_____	____ X $ ____ = $_____

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

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 $ ____ = $_____
Optician(s)	____ X $ **204** = $_____	____ X $ **174** = $_____
Optometrist Assistant/Technician(s)	____ X $ **102** = $_____	____ X $ **87** = $_____

4. OPTIONAL COVERAGE SELF-EMPLOYED INDIVIDUALS AND BUSINESS APPLICANTS

Additional Insured: Premium is for each facility under contract. (List name and address of each facility on a separate sheet of letterhead.)

# of Facility(s) X rate = premium due	
_____ X $**183** = $_____	_____ X $**156** = $_____

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%.

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

ALL APPLICANTS *MUST* COMPLETE AND SIGN THE BACK OF THE APPLICATION

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: 20+ hours per week denotes Full-Time, less than 20 hours per week is considered Part-Time.

TERRITORY 2

New York (excluding Bronx, Brooklyn, Manhattan, Queens, Staten Island, Nassau & Suffolk Counties),

TERRITORY 2 LIMITS & ANNUAL PREMIUM RATES	
$2,000,000 per incident $4,000,000 annual aggregate	$1,000,000 per incident $3,000,000 annual aggregate
Full-Time $498 per Optometrist	**Full-Time $426** per Optometrist
Part-Time or 1st Year Graduate Optometrist **$374**	**Part-Time or 1st Year Graduate** Optometrist **$320**

TERRITORY 4

New York (Bronx, Brooklyn, Manhattan, Queens, Staten Island, Nassau & Suffolk Counties)

TERRITORY 4 LIMITS & ANNUAL PREMIUM RATES	
$2,000,000 per incident $4,000,000 annual aggregate	$1,000,000 per incident $3,000,000 annual aggregate
Full-Time $1,399 per Optometrist	**Full-Time $1,196** per Optometrist
Part-Time or 1st Year Graduate Optometrist **$1,049**	**Part-Time or 1st Year Graduate** Optometrist **$897**

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 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. 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, one 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.

Notice to New York Applicants: 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.

YOU MUST SIGN AND DATE THIS APPLICATION

Signature ✗_____ **Date** _____

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 to charge my: ❑ VISA ❑ MasterCard Amount $ _____

Credit Card Number _____ Expiration Date_____

Print name exactly how it appears on card:_____

Make check payable to Seabury & Smith and return with this application to the address shown below.

For all residents except Ohio:
Seabury & Smith
Joan F. O'Sullivan, Licensed Agent
75 Remittance Drive, Suite 1788
Chicago, IL 60675-1788
1-800-503-9230
www.proliability.com/aoa
CA-0633005

Underwritten by:
Chicago Insurance Company, one of the Fireman's Fund Insurance Companies.

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