OPTOMETRIC PROTECTOR PLAN

Please complete and fax or email back to us at: Email: info@oppinsurance.com
Fax: (813)222-4370

Medical Protective E-Sign Form

To assist you with the application process, please call one of our ***OPP Account Executives to complete the application by phone, toll-free at 1-888-297-5230****, or complete and sign this form and return via fax to (813) 222-4370 or by email to info@oppinsurance.com.*

☐ **New Client*** ☐ **Existing Insured** **State** _____

DATE COMPLETED _____ **EFFECTIVE DATE** _____

NAME OF APPLICANT _____ **Lic #**_____ **State(s) Licensed in** _____

License Status ☐ **Active** ☐ **Inactive** ☐ **Pending/Temporary**

IF YOU ARE A LEGAL ENTITY PROVIDE: FEIN_____ **Date of Incorporation** _____ **State Entity Formed**_____

NAME OF YOUR LEGAL ENTITY: _____ **Type of Entity:** ☐ **Corporation** ☐ **Partnership** ☐ **LLC** ☐ **Other** _____

IF YOU HAVE A "DBA" PROVIDE NAME:_____

IS COVERAGE DESIRED FOR LEGAL ENTITY: ☐ YES ☐ NO ☐ SHARED LIMITS ☐ SEPARATE LIMITS

CONTACT INFORMATION:

NAME: _____ **EMAIL:** _____ **CELL#**_____ _____

WORK PHONE: _____ **HOME PHONE:**_____ **FAX:** _____

LIST OF THOSE PROVIDING SERVICES IN OFFICE: (IF NONE ENTER Ø)

TYPE	Total Number in Practice Location(s)	Total Number Requesting Shared Limits	Total Number Requesting Separate Limits
Optometrist		NOT AVAILABLE	
Physician/Ophthalmologist		NOT AVAILABLE	
Optometric Tech			
Opticians			
Ophthalmic Tech			

COMPLETE FOR ALL PRACTICE LOCATION(S): (must total 100%)

Loc # 1 _____% of Practice Type: ☐ Office ☐ Hospital ☐ Surgical Center ☐ Other _____

Address: _____

Practice Name Street Suite City State Zip County

Association with Practice ☐ Owner of listed practice ☐ Employee ☐ Independent Contractor

Loc # 2 _____ % of Practice Type: ☐ Office ☐ Hospital ☐ Surgical Center ☐ Other _____

Address: _____

Practice Name Street Suite City State Zip County

Association with Practice ☐ Owner of listed practice ☐ Employee ☐ Independent Contractor

Mailing Address: _____

Street Suite City State Zip

COVERAGE(S) DESIRED:

☐ **PROFESSIONAL LIABILITY** ☐ **Occurrence** ☐ **Claims Made: Need Retro Date**_____

LIMITS: ☐ **1,000,000/$3,000,000** ☐ **2,000,000/$4,000,000** **VIRGINIA ONLY:** ☐ **$2,250,000/$6,750,000**

☐ **GENERAL LIABILITY (Limits need to be the same as the Professional Liability Limits) LIMITS:** ☐ **1,000,000/$3,000,000** ☐ **2,000,000/$4,000,000**

☐ **EMPLOYMENT PRACTICES LIABILITY: Limit** ☐ **$50,000/Deductible $2500** **ARKANSAS ONLY** ☐ **$500,000/Deductible $2500**

CALIFORNIA ☐ **$100,000/Deductible $2500** **MINNESOTA ONLY** ☐ **$100,000/Deductible $2500**

If you are an Independent Contractor or Business Entity are you required to name an Additional Insured to your Professional Liability policy? ☐ **YES** ☐ **NO**

Additional Insured Name_____ **Mailing Address** _____

Are you covered by another Professional Liability Policy ☐ **Yes** ☐ **NO**

Is coverage only needed for Moonlighting (Moonlighting coverage is available if you are covered by your employer & only need coverage working elsewhere for 10 hours or less weekly) ☐ **Yes** ☐ **No**

OPTOMETRIST INFORMATION:

Name	Date of Birth MM/DD/YY	Graduation Date MM/YY	First Date in Practice MM/YY	Degree Type	# of Hours Work Weekly	Location Number	Association Membership	Any claims Y/N

*New Clients Please provide the following Information

Current Carrier:_____ ☐ Occurrence ☐ Claims Made: Retro Date_____	Limits: ☐ 1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 Other _____	Policy term: ___/___/___ to ___/___/___