Western World INSURANCE GROUP

Optometrists, Opticians & Optical Goods Stores General Liability & Professional Liability Supplemental Application

(Complete in addition to ACORD)

1. Name of Applicant: _____
2. Website Address: _____
3. List full name(s) of individual or partners and their interests: _____

_____

4. Indicate your professional specialty (check all that apply):
   ☐ Optometrist ☐ Ophthalmologist ☐ Optician ☐ Optical Goods Store ☐ Other* _____
   *Please describe: _____
5. Do you perform any surgical procedures? ☐ Yes ☐ No
6. Do you comply with all federal regulations (e.g., FDA labeling) with regard to contact lenses? ☐ Yes ☐ No
7. Do you prescribe any medications <u>other than</u> eye drops? ☐ Yes ☐ No
8. Do you request that patients who have their pupils dilated or receive eye drops remain in the office for a specified amount of time before leaving the office, or have another person drive them home? ☐ Yes ☐ No
9. Are optometrists' licenses renewed every one to three years? ☐ Yes ☐ No
10. Describe in full detail all services you provide: _____

_____

11. Total annual gross sales for services provided: $ _____
    Total annual gross sales for all optical goods sold: $ _____
12. Are you a physician or do you employ any physicians? ☐ Yes ☐ No
13. Have the dispensing opticians met all state requirements and received the necessary training? ☐ Yes ☐ No
14. Do you employ any nurse practitioners or physicians assistants? ☐ Yes ☐ No
15. In what states are you licensed or certified? _____
16. List any professional association(s) of which you are a member: _____
17. If only professional coverage is desired, name your general liability insurer, along with your policy number, policy limits, and the effective date: _____
18. Do you want your policy to cover your employees for their liability? (There is a charge.) ☐ Yes ☐ No
    NOTE: The policy already protects *you* for the acts of your employees.

If the Applicant is an Individual (not a Corporation), please answer questions 19 through 22.

19. Are you an employee of another person or organization? ☐ Yes ☐ No
    If yes, what is the name of your employer? _____
20. Do you have any management or supervisory responsibilities? ☐ Yes ☐ No
    If yes, describe: _____
21. If you contract your services to others on an independent contractor basis, for whom do you work? _____

_____

22. Are you in private practice? ☐ Yes ☐ No

SEXUAL MOLESTATION COVERAGE: Sexual Molestation liability is offered for an additional premium charge.
If sexual molestation coverage is not desired, please check here ☐ Coverage is not requested.

23. Have you had any incidents or claims brought against you for sexual molestation or any other allegations of misconduct? ☐ Yes ☐ No
24. If you have employees, are there written guidelines in place regarding sexual misconduct? ☐ Yes ☐ No
    If **NO**, please explain: _____
25. Please check the limits you are requesting: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000

_____ _____
Applicant's Signature Date

_____ _____
Title Producing Agent