Harold Diers & Co.
11635 Arbor, Suite 230
Omaha, NE 68144
Toll-Free: 1-800-444-1330, Ext 3
Email: marilyn@hdiers.com

Medical Protective E-Sign Form

To assist you with the application process, please contact Marilyn Diers Toll-free at 1-800-444-1330, Ext 3. Please complete and sign this form and Return via fax to (402) 697-7083 or by email to marilyn@hdiers.com.

☐ **New Client**** ☐ **Existing Insured** **State Nebraska**

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: *** Coverage may not available in all states**

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

LIMITS: ☐**1,000,000/$3,000,000** ☐**2,000,000/$4,000,000** ☐**3,000,000/$5,000,000** ☐**5,000,000/$7,000,000**

☐ **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 $2,500**

ARKANSAS ☐ **$500,000/Deductible $2,500** **CALIFORNIA** ☐**$100,000/Deductible $,2500** **MINNESOTA ONLY** ☐**$100,000/Deductible $2,500**

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: ☐**Yes** ☐**No**

(Moonlighting coverage is available if you are covered by your employer & only need coverage working elsewhere for 10 hours or less weekly)

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 ___/___/___