

For ophthalmology practices, including cataract, retina and injections, glaucoma, oculoplastics, and pediatric eye care. Refractive surgery centers use CWCO-SUP-LASIK. Complete with ACORD 125 and the carrier's medical professional liability application. Attach a CV and board certification for each provider, a list of procedures performed with annual volumes, and ten years of loss runs for every provider and the practice entity.

## 1 APPLICANT / PRACTICE INFORMATION

|                        |                      |                      |                      |
|------------------------|----------------------|----------------------|----------------------|
| PRACTICE LEGAL NAME    | DBA                  | FEIN                 | YEARS IN PRACTICE    |
| <input type="text"/>   | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| PRIMARY OFFICE ADDRESS | CITY / STATE / ZIP   | WEBSITE              |                      |
| <input type="text"/>   | <input type="text"/> | <input type="text"/> |                      |

**Entity type:**  
☐ Sole proprietor    ☐ Professional corporation / PLLC    ☐ LLC    ☐ Partnership    ☐ MSO / private-equity affiliated

|                         |                            |                         |
|-------------------------|----------------------------|-------------------------|
| PRIMARY CONTACT / TITLE | PHONE                      | EMAIL                   |
| <input type="text"/>    | <input type="text"/>       | <input type="text"/>    |
| GROUP NPI               | NUMBER OF OFFICE LOCATIONS | PROPOSED EFFECTIVE DATE |
| <input type="text"/>    | <input type="text"/>       | <input type="text"/>    |

## 2 OPERATIONS

### Providers to be insured:

| NAME | SPECIALTY / SUBSPECIALTY | BOARD CERTIFIED (Y/N) | YEARS IN PRACTICE | HOURS PER WEEK |
|------|--------------------------|-----------------------|-------------------|----------------|
|      |                          |                       |                   |                |
|      |                          |                       |                   |                |
|      |                          |                       |                   |                |
|      |                          |                       |                   |                |
|      |                          |                       |                   |                |

### Staff:

Physicians     PAs / NPs     CRNAs     Nurses / MAs     Other employees     Patient visits per year

### Where care is provided (check all that apply):

☐ Office    ☐ Hospital (privileges)    ☐ Ambulatory surgery center    ☐ Practice-owned ASC or procedure suite    ☐ Nursing homes / post-acute  
☐ Telehealth

2-1 Do any providers work as locum tenens or moonlight for other employers? ☐ Yes ☐ No  
 IF YES, EXPLAIN

2-2 Do PAs or NPs see patients without a physician on site? ☐ Yes ☐ No  
 IF YES, EXPLAIN

### Services (check all that apply):

☐ Cataract    ☐ Premium IOLs    ☐ Retina / intravitreal injections    ☐ Retinal surgery    ☐ Glaucoma surgery / MIGS    ☐ Cornea  
☐ Oculoplastics    ☐ Pediatric / ROP screening    ☐ Refractive (LASIK / PRK)    ☐ Optometry / optical shop

|                             |                       |                                  |                             |
|-----------------------------|-----------------------|----------------------------------|-----------------------------|
| CATARACT SURGERIES PER YEAR | PREMIUM IOL SHARE (%) | INTRAVITREAL INJECTIONS PER YEAR | GLAUCOMA SURGERIES PER YEAR |
| <input type="text"/>        | <input type="text"/>  | <input type="text"/>             | <input type="text"/>        |

## 3 EXPOSURE & RISK QUESTIONS — CATARACT & IOL VERIFICATION

A state medical board treated a wrong-power lens implant as wrong-site surgery and imposed a fine and CME even though the patient never filed a claim.

3-1 Is the IOL model and power read back against the biometry printout at the time-out? ☐ Yes ☐ No  
 IF NO, EXPLAIN

3-2 Does the surgeon personally confirm the lens before it is opened? ☐ Yes ☐ No  
 IF NO, EXPLAIN

3-3 Are premium IOL patients given written expectations and costs? ☐ Yes ☐ No  
IF NO, EXPLAIN

3-4 Is post-op care comanaged with optometrists? ☐ Yes ☐ No  
IF YES, EXPLAIN

3-5 If yes to 3-4, is there a written comanagement agreement? ☐ Yes ☐ No  
IF NO, EXPLAIN

3-6 Does any provider own or invest in an ASC or office surgery suite? ☐ Yes ☐ No  
IF YES, EXPLAIN

3-7 Do providers screen for retinopathy of prematurity? ☐ Yes ☐ No  
IF YES, EXPLAIN

3-8 If yes to 3-7, is every exam and follow-up date tracked? ☐ Yes ☐ No  
IF NO, EXPLAIN

#### 4 EXPOSURE & RISK QUESTIONS — INJECTIONS & INFECTION CONTROL

Intravitreal injections rose to 36% of OMIC endophthalmitis claims. In one outbreak, eight patients were infected after staff split single-dose vials and compounded syringes; seven sued.

**Injection syringes are prepared by:**

☐ Physician at the time of injection ☐ Office staff ☐ 503B outsourcing facility ☐ Pharmacy

4-1 Are single-dose vials ever used for more than one patient? ☐ Yes ☐ No  
IF YES, EXPLAIN

4-2 Are additives ever mixed into injection drugs? ☐ Yes ☐ No  
IF YES, EXPLAIN

4-3 Are povidone-iodine and a lid speculum used for every injection? ☐ Yes ☐ No  
IF NO, EXPLAIN

4-4 Are bilateral same-day injections done with separate lots and set-ups? ☐ Yes ☐ No  
IF NO, EXPLAIN

4-5 Are endophthalmitis rates tracked? ☐ Yes ☐ No  
IF NO, EXPLAIN

4-6 Has the practice had an infection cluster or outbreak investigation? ☐ Yes ☐ No  
IF YES, EXPLAIN

#### 5 PAYROLL, SALES & REVENUE

| ANNUAL REVENUE (\$)  | SURGERY / OPTICAL REVENUE (\$) | MEDICARE / MEDICAID REVENUE (\$) | TOTAL ANNUAL PAYROLL (\$) |
|----------------------|--------------------------------|----------------------------------|---------------------------|
| <input type="text"/> | <input type="text"/>           | <input type="text"/>             | <input type="text"/>      |

#### 6 PRIOR INSURANCE & LOSS HISTORY

| CURRENT CARRIER / LIMITS PER PROVIDER | ENTITY LIMITS (SEPARATE OR SHARED) | RETROACTIVE DATE     |
|---------------------------------------|------------------------------------|----------------------|
| <input type="text"/>                  | <input type="text"/>               | <input type="text"/> |

**Current policy form:**

☐ Claims-made ☐ Occurrence ☐ Self-insured / hospital program ☐ Risk retention group

| DATE OF INCIDENT     | PROVIDER / ALLEGATION | TOTAL INCURRED (\$)  | OPEN / CLOSED        |
|----------------------|-----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/>  | <input type="text"/> | <input type="text"/> |

6-1 Has any claim or board complaint involved endophthalmitis or a wrong lens? ☐ Yes ☐ No  
IF YES, EXPLAIN

|                 |                                                                                                                   |                                                          |
|-----------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 6-2             | Has any provider's license, DEA registration, or hospital privileges been restricted, suspended, or investigated? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF YES, EXPLAIN |                                                                                                                   |                                                          |
| 6-3             | Will any departing provider need tail (extended reporting) coverage?                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF YES, EXPLAIN |                                                                                                                   |                                                          |
| 6-4             | Has any coverage been declined, cancelled, or non-renewed?                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF YES, EXPLAIN |                                                                                                                   |                                                          |
| 6-5             | Is the applicant aware of any incident or circumstance that could give rise to a claim?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF YES, EXPLAIN |                                                                                                                   |                                                          |

## 7 RISK MANAGEMENT & SAFETY

|                |                                                                                                |                                                          |
|----------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 7-1            | Is every test result and referral tracked until the patient is notified and follow-up is done? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF NO, EXPLAIN |                                                                                                |                                                          |
| 7-2            | Does the practice document informed consent for every procedure?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF NO, EXPLAIN |                                                                                                |                                                          |
| 7-3            | Are new procedures and locations reported to the insurer before starting?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF NO, EXPLAIN |                                                                                                |                                                          |
| 7-4            | Are patients called the day after surgery?                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF NO, EXPLAIN |                                                                                                |                                                          |

## 8 SIGNATURE & FRAUD WARNING

The undersigned declares that the statements and answers given in this supplemental are true, complete and correct to the best of their knowledge, and that no material fact has been withheld or misstated. The applicant agrees that this supplemental, together with all ACORD applications and attachments, forms the basis of any submission to insurers and may be relied upon by them. Signing this supplemental does not bind coverage. This supplemental is an intake document prepared by Cory Washington & Co. LLC to support carrier submission; it does not itself provide coverage.

**FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. State-specific fraud warnings appear on the insurer's application.**

|                                                   |                                     |      |
|---------------------------------------------------|-------------------------------------|------|
| APPLICANT / AUTHORIZED SIGNATURE (TYPE FULL NAME) | TITLE                               | DATE |
|                                                   |                                     |      |
| PRODUCER — CORY WASHINGTON & CO. LLC              | PRODUCER SIGNATURE (TYPE FULL NAME) | DATE |
|                                                   |                                     |      |