

SERFF Tracking Number: AGNY-125339030 State: Arkansas
Filing Company: Granite State Insurance Company State Tracking Number: AR-PC-07-026606
Company Tracking Number: AIC-07-EO-24
TOI: 11.2 Medical Malpractice - Occurrence Only Sub-TOI: 11.2019 Optometry
Product Name: General Healthcare Providers Professional Liability Program
Project Name/Number: General Healthcare Providers Professional Liability Program/AIC-07-EO-24

Filing at a Glance

Company: Granite State Insurance Company

Product Name: General Healthcare Providers Professional Liability Program SERFF Tr Num: AGNY-125339030 State: Arkansas

Professional Liability Program

TOI: 11.2 Medical Malpractice - Occurrence Only SERFF Status: Closed State Tr Num: AR-PC-07-026606

Sub-TOI: 11.2019 Optometry

Co Tr Num: AIC-07-EO-24

State Status:

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding

Author: Myron Harry

Disposition Date: 10/31/2007

Date Submitted: 10/30/2007

Disposition Status: Approved

Effective Date Requested (New): 12/01/2007

Effective Date (New):

Effective Date Requested (Renewal): 12/01/2007

Effective Date (Renewal):

General Information

Project Name: General Healthcare Providers Professional Liability Program

Status of Filing in Domicile: Pending

Project Number: AIC-07-EO-24

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 10/31/2007

State Status Changed: 10/31/2007

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Granite State Insurance Company (the "Company") currently has on file with your Department its General Healthcare Provider Professional Liability Program (the "Program"). The Company submits for your review and approval its Optometrists Professional Liability Insurance Application to be used with this Program.

Please refer to the attached forms listing for information about this submission.

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Company and Contact

Filing Contact Information

Myron Harry, myron.harry@aig.com
 175 Water Street - 17th Floor (212) 458-7057 [Phone]
 New York, NY 10038 (212) 458-7077[FAX]

Filing Company Information

Granite State Insurance Company CoCode: 23809 State of Domicile: Pennsylvania
 70 Pine Street Group Code: Company Type:
 New York, NY 10270 Group Name: State ID Number:
 (212) 770-7000 ext. [Phone] FEIN Number: 02-0140690

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Granite State Insurance Company	\$50.00	10/30/2007	16392789

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	10/31/2007	10/31/2007

SERFF Tracking Number: *AGNY-125339030* *State:* *Arkansas*
Filing Company: *Granite State Insurance Company* *State Tracking Number:* *AR-PC-07-026606*
Company Tracking Number: *AIC-07-EO-24*
TOI: *11.2 Medical Malpractice - Occurrence Only* *Sub-TOI:* *11.2019 Optometry*
Product Name: *General Healthcare Providers Professional Liability Program*
Project Name/Number: *General Healthcare Providers Professional Liability Program/AIC-07-EO-24*

Disposition

Disposition Date: 10/31/2007

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AGNY-125339030 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Form Listing and Filing Schedule	Approved	Yes
Form	Optometrist Professional Liability Insurance Application	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Optometrist Professional Liability Insurance Application	96353	10/07	Application/ New Binder/Enrollment		0.00	96353(10-07) Optometrist PL Insurance Application.pdf



Name of Insurance Company to which Application is made _____ (herein called the "insurer", "company", etc.)

OPTOMETRIST PROFESSIONAL LIABILITY INSURANCE APPLICATION OCCURRENCE

If this is for a group policy please submit individual applications for each optometrist

I. GENERAL INFORMATION

- 1. Name of Applicant:
2. Corporate Entity Name (include d/b/a):
3. Type of practice [] Sole Proprietorship [] Partnership [] Corporation [] LLC
4. Employment Status:
a. Do you own your own practice? [] Yes [] No
b. Do you work for others? [] Yes [] No
If "Yes" please give name of employer:
5. Business Address: Street City State Zip
6. Mailing Address:(if different than business address): Street City State Zip
7. Business Telephone Number: (Area Code) Business Fax: (Area Code)
8. E-Mail Address: Website:
9. How did you hear about us?
[] Convention
[] Colleague
[] Advertisement
[] Mailer
[] Cotterell, Mitchell & Fifer Website
[] Association
[] Other
10. Are you a member of a professional association? [] Yes [] No
If "Yes", please list:

II. COVERAGE INFORMATION

Please check the boxes for the coverage you are requesting:

- 1. Requested Effective Date:
2. Limits of Liability
[] \$1,000,000/\$3,000,000 [] \$2,000,000/\$4,000,000 [] Other

III. EXPOSURE INFORMATION

1. How many hours per week do you practice? _____
2. How many years have you been in practice? _____
3. In chronological order, please complete the following for all states where you have practiced in the last five years.

Name	License Number	License Effective Date	State of License

4. Do you perform any laser or surgical procedures? Yes No
If "Yes", please attach a separate sheet with full particulars.
5. a. Therapeutic Pharmaceutical Agent (TPA) #: _____
 b. D.E.A. License #: _____
 c. Has your TPA or D.E.A. license ever been subject to probation, revoked, or suspended? Yes No
If "Yes", please attach a separate sheet with full particulars.

IV. HISTORICAL CARRIER INFORMATION

Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies. Begin with the current policies on the top line. If Claims Made, give retroactive date:

PRIMARY	Policy Period	Insurer	Premium	Limits	CM (w/Retro) Or Occurrence
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL					
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL					
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL					
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL					
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL					

V. CLAIMS HISTORY

Please submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation dates with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

1. Have you or any employee ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency or ever been the subject of any ethics investigation at local, state, or national level? Yes No

If "Yes", please attach a separate sheet with full particulars.

2. Has any malpractice claim or suit ever been brought against you or any employee? Yes No

3. Has any Insurance ever been cancelled or non-renewed? Yes No

NOTE: MISSOURI APPLICANTS DO NOT RESPOND

4. Are you aware of any circumstance, accident, or loss which has occurred after the Retroactive date that may result in a claim? Yes No

If "Yes", please attach a separate sheet with full particulars.

5. Have you ever been involved in any Administrative Hearings? Yes No

If "Yes", please attach a separate sheet with full particulars.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: 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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicant's Signature: _____

Title: _____

Date: _____

Name of Agent: _____

Submitted by: _____

Date: _____

Address: _____

License #: _____

(Florida/Iowa)

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TOI: *11.2 Medical Malpractice - Occurrence Only* *Sub-TOI:* *11.2019 Optometry*
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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty **Review Status:** Approved 10/31/2007

Comments:

Attached please find a PCTD Transmittal.

Attachment:

10-07 PCTD Transmittal - Form.pdf

Satisfied -Name: Form Listing and Filing Schedule **Review Status:** Approved 10/31/2007

Comments:

Attached please find a Form Listing and a Form Filing Schedule.

Attachments:

Form Listing - Opometrist PL Appl.pdf

Form Filing Schedule - PC FFS.pdf

Property & Casualty Transmittal Document

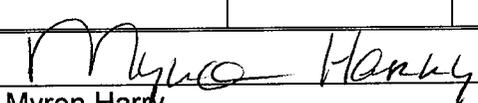
1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #
American International Group, Inc	012

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Granite State Insurance Company	PA	23809	02-0140690	

5. Company Tracking Number	AIC-07-EO-24
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Myron Harry 175 Water Street, 17 th Fl. New York, NY 10038	Filings Analyst	(212) 458 7057	(212) 458 7077	Myron.harry@aig.com
7.	Signature of authorized filer				
8.	Please print name of authorized filer		Myron Harry		

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	11.0 – Medical Malpractice
10. Sub-Type of Insurance (Sub-TOI)	11.0019 - Optometrist
11. State Specific Product code(s) (if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: December 1, 2007 Renewal: December 1, 2007
15. Reference Filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	October 30, 2007
19. Status of filing in domicile	<input checked="" type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20.	This filing transmittal is part of Company Tracking #	AIC-07-EO-24
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21.	Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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The Company listed in item 4 above submits for your review and approval its Optometrists Professional Liability Insurance Application, to be used with our General Healthcare Professional Liability Program – Policy Form No. 74829(1/00).

Please refer to the attached form listing for information about this filing.

22.	Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
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Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Form Listing

Form Title	Form No.	Form Type	New or Replacement	Form No. Being Replaced	Mandatory or Optional or Clarifies	Restricts, Broadens or Clarifies	Rate or Premium Impact	Description of Form
1 Optometrist Professional Liability Insurance Application	96353 (10/07)	Application	New		Mandatory		No	Application for Optometrists coverage.

Yes or No

- A = Application
- D = Declarations
- E = Endorsement
- P = Policy
- O = Other (Please explain)

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	AIC-07-EO-24			
2.	This filing corresponds to rate/rule filing number <small>(Company tracking number of rate/rule filing, if applicable)</small>				
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Optometrist Professional Liability Insurance Application	96353 (10/07)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1