KANSAS OPTOMETRIC ASSOCIATION
Warranty Statement
Request for Cyber Liability (e-MD™) Limits

I. Name of Applicant: ______________________________
(as it should appear on the policy)

Mailing Address:______________________________

City:______________________ State:__________Zip Code: ____________

Phone: ____________________ Email: ______________________

Web Site: ____________________ No. of years in business ____________

Number of full time equivalent optometrists to be covered under policy:__________

II. The applicant represents to the best of its knowledge and belief that it has not experienced any claims or is aware of any circumstances that may give rise to a claim that would have been covered by this policy in the last five (5) years.

III. The applicant represents to the best of its knowledge and belief that the statements set forth herein are true and complete.

IV. It is agreed this application shall be the basis of insurance and will be attached to and made part of the policy should a policy be issued.

V. The applicant further represents that if the information supplied on this application changes between the date of the application and the inception date of the policy period, the applicant will immediately notify the underwriter of such a change, and the underwriter may modify or deny coverage.

OPTION DESIRED	**PREMIUM**
□ **$50,000 Coverage Limit**	$______________
Requested effective date (no backdating):	______________

Signed: ______________________________ Date: ____________________

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

Print Name: ______________________________ Title:______________

Return Application To:

KaMMCO
ATTN: Underwriting
623 SW 10th Avenue
Topeka, KS 66612

FAX: 785.232.4704