**MEDICAL SERVICES**

**PROFESSIONAL LIABILITY APPLICATION**

**APPLICANT**

1. Name of the Insured:

Address:

1. Trading Name (if different from above):

Practice / Trading Address (if different from above):

* **If cover is required for more than one location, please attach a list of all addresses.**

1. Have you ever engaged in a similar activity under a different name?  Yes  No

**If yes**, please give full details:

1. Is this a new company (formed within the past 3 years)  Yes  No If yes, please attach resume(s) of principal(s)
2. Is the applicant controlled, owned or associated with any other company (including franchise)?  Yes  No

If yes, describe:

1. Web Site Address:

**OPERATIONS**

1. Fees from all operations: Last 12 months (expiring) $      Next 12 months (estimates) $

(If new business please state estimated income for the forthcoming 12 months)

List all business activities/specializations and duties performed (also provide brochures or promotional materials):

Activity % of income

           %

           %

           %

           %

           %

           %

1. Do operations/services include:

Laser Vision Correction  Midwife duties  Sale of medication online  Laser tattoo removal  None applicable

Home, Personal or Respite Care:  Yes  No If yes,

* 1. Is the applicant a licensed nurse ?  Yes  No
  2. Does the applicant dispense medication?  Yes  No
  3. Do any employees provide any manual handling/lifting of patients/residents up

from their sets/beds etc.?  Yes  No

If Yes, note training provided:

3D Imaging Ultrasound, Medical Ultrasound and Sonographer:  Yes  No If yes,

* 1. Are scans for medical diagnostic purposes?  Yes  No
  2. Do you provide any diagnostic or any interpretation of the scans to anyone?  Yes  No

Dieticians and Nutritionists:  Yes  No If yes,

* 1. Are recommendations made that exceed manufacturing or regulatory limits for dosage?  Yes  No

Veterinarians:  Yes  No If yes,

* 1. State largest value of animal that you perform services on: $
  2. Do you provide services to animals in commercial operations?  Yes  No

Counseling, Hypnotherapy or Psychologist:  Yes  No If yes,

* 1. Do you use recovered/regression memory therapy?  Yes  No
  2. Are any hypnosis services in a non-medical setting (ie entertainment /social purposes)  Yes  No

1. Does the application work with professional athletes?  Yes  No If Yes, please explain:

1. Does applicant work with children under the age of 16?  Yes  No If yes, describe ages(s) and circumstances:

1. Do you provide teaching or instruction?  Yes  No If yes, please advise:

Approx # students/year       approx # hours/week       annual income/year from instruction $

1. a) Is the applicant currently enrolled as a student?  Yes  No
2. Are any of the employees currently enrolled as students?  Yes  No
3. Do any students operate (perform services) outside of the school or program?  Yes  No
4. # of Employees: Full time       Part time
5. Details on all Partners, Directors and/or Practitioners (please also provide resumes of all principals)

Name Professional Qualifications Date Qualified Years in Practice

1. Does the applicant sell any products?  Yes  No If yes,
2. estimated annual revenue: $
3. Are any products imported?  Yes  No If yes, please attach details
4. Are any products exported?  Yes  No If yes, please attach details
5. Are any products manufactured by applicant?  Yes  No If yes, please attach details
6. Are any products repackaged or relabelled for resale?  Yes  No If yes, please attach details
7. Are all products approved for use under the Canada Food and Drug Act?  Yes  No
8. Does the applicant have an locations OR operations outside of Canada?  Yes  No If yes,

Country Revenue # of Employees

      $

      $

      $

1. Is the applicant engaged in any business or profession other than described above?  Yes  No If yes, describe:

1. Is a license required in order for the applicant to practice?  Yes  No License #:
2. Do all employees carry a valid license  Yes  No
3. Do you obtain satisfactory consent in writing from each patient prior to starting treatment?  Yes  No (attach form)
4. How long are patients records kept for?
5. Does the applicant have a record of disciplinary action with the applicable

professional association? (including revocation or suspension of a license)  Yes  No If Yes, please explain:

**INSURANCE** (see Property Supplement for additional coverages)

1. Insurance required: EACH CLAIM LIMITS: $

AGGREGATE LIMIT: $

DEDUCTIBLE: $

CGL:  Yes  No $

1. Are you currently insured for Medical Professional Liability?  Yes  No
2. **If yes**, please indicate the name of the Insurer:
3. Is coverage through an association:  Yes  No
4. Is such coverage offered on:  Occurrence Basis  Claim-made Basis
5. If the current coverage is on a claim-made basis, what is the retroactive date?
6. What is your current policy limit? $      deductible? $
7. If you are presently insured, are renewal terms being offered?  Yes  No

**If no**, please state reason:

1. To your knowledge, has any company declined or terminated the insurance for you, any

present partner or officer or for any predecessor in the business, past partners or officers?  Yes  No

**If yes,** provide details:

1. Has any order to cease & desist, claim, written demand, or civil proceeding for compensatory

damages or ever been made to your knowledge against you, any business predecessors, or

any of the present or former partners or officers?  Yes  No

1. Are you aware of any act, error, omission or circumstances which could give rise to a claim

against you or any predecessor in business, or any present or former partner or officer?  Yes  No

**IF THE ANSWER TO EITHER 25 OR 26 IS YES, ATTACH LIST OF ANY INCIDENTS OCCURING IN THE PAST 5 YEARS**

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 25 OR 26 OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

1. Additional Interests

Name Address Interest

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed or misstated any material facts and I/we agree that this declaration shall be the basis of any binder or contract or insurance with the Insurer, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurer to the issue of the insurance nor the Applicant to the purchase of the insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 25 or 26 of this application, the Insurer shall be immediately notified in writing of such information.

NAME OF APPLICANT:

Signature (Signing Officer) Title Date

**BROKER**

Agent/Broker Name:       Company:

Phone:       Email:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_