TOTTEN GROUP INSURANCE

Watts: 1-888-868-8367 (TOTTENS) Fax: 1-888-232-2205

New Submissions: professionalliability@tottengroup.com Website: www.tottengroup.com

MEDICAL STUDENT PROFESSIONAL LIABILITY INSURANCE APPLICATION

This is an application form for a Claims Made Policy.

Underwriters will rely upon each and every response given in this Application Form and any Supplementary App lication Form in deciding whether or not to insure this risk and if so at what premium, terms and conditions. Underwriters regard every response to be material to their decisions. Failing to answer or answering any question below incorrectly could invali date any policy of insurance written by Underwriters for this risk.

We have a professional duty of confidentiality and are committed to holding personal information in strict confidence. The information provided to us will only be disclosed where required by law to do so or required to do so in conducting negotiations with third parties, such as insurance companies, on your behalf.

We will further safeguard the security of such information in a manner appropriate to sensitivity of that information.

- Please complete all questions. If there is no answer, write "none" or "N/A" in the space provided

1. Name of Medical Student _____
2. Foreign Address _____

   Canadian Address _____
3. Date of Birth _____ Place of Birth _____
4. Country of Citizenship _____

   Coverage is limited to Canadian Citizens Only

   Please attach a copy of the Applicant's Curriculum Vitae
6. Medical School (School at which applicant is a Student) _____
7. Please provide anticipated month/year of graduation _____
8. Medical Elective Placement School _____
9. Duration of Medical Elective Program (MM/DD/YYYY) From _____ To _____
10. Please provide a description of the medical elective program(s) that the insured will be participating in _____
11. Name of Supervising Physician _____

    (Please complete for all anticipated Medical Student Elective Placements)
12. Will you be providing direct patient care? ☐ Yes ☐ No

    If No, are your activities limited to observation? ☐ Yes ☐ No
13. Coverage requested

Limit of Liability	Deductible
☐ $1M per claim/$3M Annual Aggregate	$2,500
☐ $2M per claim/$2M Annual Aggregate	$2,500
☐ $3M per claim/$3M Annual Aggregate	$2,500
☐ $5M per claim/$5M Annual Aggregate	$2,500

14. Has the Medical Student ever been declined, non-renewed or cancelled by any insurer for Professional Liability insurance ☐ Yes ☐ No

    If Yes, please explain _____

15. In the last five (5) years, has the Medical Student ever had a claim made against him/her? ☐ Yes ☐ No

    a. Date of claim
    b. Claimant's name
    c. Nature of claim
    d. Amount of indemnity payment and amount of defense costs
    e. Final dispositions or current status of claim

16. Is the Medical Student aware of any situation or circumstance which may reasonably result in a claim? ☐ Yes ☐ No

    If Yes, please describe in detail _____

Without limitation of any other remedy available to the Insurer, it is hereby agreed that if there be knowledge of any such fact, circumstance or situation, any claim or action subsequently emanating there from is excluded from coverage under the proposed insurance.

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. The undersigned also warrants that they have not suppressed or misstated any material facts.

If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned warrants he or she will immediately report such changes to the Insurer.

Signing of this Application does not bind the undersigned to purchase this insurance, nor does it bind the Insurer to complete this insurance. However, should the Insurer bind and issue a policy, this Application shall serve as the basis of such contract and will be attached to and form part of the policy/

Signed _____ Date _____

(Medical Student)

Name (please print) _____ Title/Position _____