



Victor Canada  
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# Application

## Errors and Omissions Insurance for Diagnostic Laboratories

**Submitting Broker, please complete the following to assist us in processing this submission:**

Name of Brokerage: \_\_\_\_\_

Name of Broker Contact: \_\_\_\_\_

Brokerage Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

For renewal purposes only: Policy Number: \_\_\_\_\_ ISN (Client's Number): \_\_\_\_\_

### THE APPLICANT

1. Name of Applicant: \_\_\_\_\_

\_\_\_\_\_

If more than one legal entity, please indicate the relationship between each: \_\_\_\_\_

\_\_\_\_\_

(Please note that an insurance policy cannot be shared unless there is a financial interest.)

2. Website Address (if applicable): \_\_\_\_\_

3. Address: \_\_\_\_\_

\_\_\_\_\_

4. Location of Branch Offices: \_\_\_\_\_

5. Date operations began: \_\_\_\_\_

6. Please indicate the type of licence held by the Applicant: \_\_\_\_\_

7. Please list all provinces where the Applicant is currently licensed to operate a Medical Diagnostic Laboratory:

\_\_\_\_\_

8. Please indicate the Applicant's gross annual revenue:

(a) Previous Year: \$ \_\_\_\_\_

(b) Anticipated for Next Year: \$ \_\_\_\_\_

9. Please provide a breakdown of the number of employees per location (if more space is required, use a separate sheet):

Location(s)	Registered Technicians/Technologists	Doctors	Other (specify)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. If doctors are listed in question 8, please provide the following for each:

Name	Discipline	Professional Liability Insurer
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**N.B. PLEASE NOTE THAT THIS PROPOSED ERRORS AND OMISSIONS INSURANCE EXCLUDES THE SERVICES OF PHYSICIANS, SURGEONS AND DENTISTS WHEN THEY CARRY OUT OR NEGLECT TO CARRY OUT AN ACT IN THE PRACTICE OF THEIR PROFESSION.**

11. Please indicate the percentage of services performed of each test in relation to overall testing as indicated below:

Test	Percentage	Test	Percentage
Microbiological	_____	Immunohematological	_____
Serological	_____	Cytological	_____
Chemical	_____	Pathological	_____
Hematological	_____	Other (specify)	_____
Biophysical	_____	Immunohematological	_____

12. Please indicate whether the Applicant is engaged in the performance of any medical research activities, human or otherwise? YES  NO

PLEASE NOTE THAT THE COVERAGE APPLIED FOR EXCLUDES MEDICAL RESEARCH ACTIVITIES, HUMAN OR OTHERWISE.

13. Please provide full details of "in-house" quality control procedures implemented: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Has the Applicant ever been subject to any revocation or suspension of licence imposed by a licensing authority? YES  NO

If yes, please provide details.

15. Does the Applicant provide services or perform activities outside Canada or for clients who are outside Canada? YES  NO

If yes, please provide full details for our review and acceptance, and indicate the services provided as well as the location and the gross annual fees or income from the past year and anticipated for the next year.

**INSURANCE COVERAGE - If you are renewing your policy with Victor, do not complete this section.**

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16. (a) Has the Applicant ever previously purchased professional liability or errors and omissions insurance? YES  NO

(b) If yes, please provide the following details for the last three years:

Insurer	Policy Period	Expiring Premium	Limit	Deductible
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____

(c) With respect to (b) above, please indicate if such coverage was offered on an occurrence basis or claims-made basis: \_\_\_\_\_

If claims-made, what was the retroactive date of the policy (dd/mm/yyyy)? \_\_\_\_\_

17. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused? YES  NO

If yes, please provide details.

**LOSS EXPERIENCE - If you are renewing your policy with Victor, do not complete this section.**

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18. (a) In the past, has the Applicant or any of their employees ever been the recipient of any allegations of professional negligence in writing or verbally? YES  NO

(b) Is the Applicant or any of their employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? YES  NO

If yes, please provide details.

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURERS, IT IS AGREED THAT, IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

**LIMITS REQUESTED**

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19. Per claim: \$ \_\_\_\_\_ Per policy period: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

Please note that the proposed insurance will be effective at a date determined by the insurers.

**APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM**

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I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to Victor Insurance Managers Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize Victor Insurance Managers Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on Victor's privacy policy, please contact [privacypolicyinquiries@victorinsurance.com](mailto:privacypolicyinquiries@victorinsurance.com).

## **DECLARATIONS AND SIGNATURE**

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The undersigned Applicant for this insurance declares that, to the best of their knowledge and belief, the statements set forth herein are true and correct, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned agrees that, if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant further agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy.

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Name of Applicant (please print)

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Signature of Applicant

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Date (dd/mm/yyyy)