



Victor Canada  
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# Application

## Errors and Omissions Insurance for Podiatrists

**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. (If you are renewing your policy with Victor, do not complete this question.)

Year of Graduation	Schooling	Institution where residency completed	What licences are held?	Have any licences been suspended or removed?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

6. Do any licences require continuing education? YES  NO

If so, how many hours have you completed, on average over the past five years? \_\_\_\_\_

7. Practice:

Services	Response		Number of procedures performed annually
	Yes	No	
Palliative	_____	_____	_____
Soft Tissue	_____	_____	_____
Bone Surgery	_____	_____	_____
Digital	_____	_____	_____
Forefoot	_____	_____	_____

Type	Response (✓)
Solo	_____
Partnership	_____
Associates or Clinics	_____

8. If in a clinic setting, are there professionals other than podiatrists who practice there? YES  NO

If yes, please provide details.

9. Do you have a separate "surgical" suite where you perform surgery? YES  NO

If no, where do you offer surgical services? \_\_\_\_\_

10. Please specify special care services, if any: \_\_\_\_\_

11. Do you have necessary equipment for emergency care (i.e., oxygen, ambulance services, etc.)? YES  NO

12. Please list all employees and volunteers of the Applicant, excluding physicians and surgeons, and their respective duties:

Name	Duties	Education	Years of Exp.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. 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.

**QUALITY CONTROL FOR CARE AND SERVICES**

14. Is there an established system to identify risk situations? YES  NO

If yes, please provide details.

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

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15. (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)? \_\_\_\_\_

16. 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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17. (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.

**COVERAGE REQUESTED**

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

19. Please indicate your choice:  1 Year  2 Years

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.

\_\_\_\_\_  
Name of Applicant (please print)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date (dd/mm/yyyy)