beazley

MEDICAL MALPRACTICE INSURANCE APPLICATION

THIS APPLICATION IS FOR A CLAIMS MADE POLICY

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION WHERE APPLICABLE
- ☐ **Résumés / Certifications for Principals and Key Employees**
- ☐ **Consent Forms / Waivers / Protocols**

1. GENERAL INFORMATION

1. Name of Organization or Legal Entity (Applicant) including any subsidiaries:

   _____

   (please show complete name as you wish it to appear on the policy)

2. Address (Not P.O. Box):

   _____

   _____

   Website: _____

3. How many locations are there? _____
   Please list all other locations including full address on a separate sheet.

4. Coverage requested:

   Limit of Liability: ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐ Other: $ _____
   Deductible: ☐ $1,000 ☐ $5,000 ☐ $10,000 ☐ Other: $ _____

   Target Premium: $ _____

2. CLINIC INFORMATION

5. Type of Organization (please provide full details of all activities):

   _____

   _____

6. Date operations began: _____

7. Ownership structure (please identify partners and percentages of ownership):

   _____

   _____

   _____

8. Within the next twelve (12) months are there plans to obtain another locations or expand operations? ☐ YES ☐ NO
   If YES, where and how? _____

9. Name of Principal(s): _____

10. Qualifications of Principal(s): _____

11. Number of Employees: Full-time: _____ Part-time: _____

12. Please complete the following:

STAFF DETAILS	NEXT YEAR	CURRENT YEAR	LAST YEAR
NUMBER OF FULL TIME PRACTITIONERS			
NUMBER OF PART TIME PRACTITIONERS			
NUMBER OF NURSING STAFF			
NUMBER OF ADMINISTRATION STAFF			
OTHER (describe)_____			

13. If applicable, are all practitioners operating in the Organization licensed/certified to practice in the province? ☐ YES ☐ NO
If NO, please provide a reason:

_____

_____

14. Please provide the numbers of practitioners in the Clinic by category (if applicable):

Audiologists		Laboratory Technicians	
Optometrists		Chiropractors	
Perfusionists		Physical Therapists	
Psychologists		Pulmonary Therapists	
Massage Therapists		Registered Pharmacists	
X-ray Technicians		Dentists	
Gynecologists		Surgeons	
General Practitioners		Other (please identify practice):	

PLEASE NOTE THAT THIS PROPOSED INSURANCE WILL NOT INCLUDE COVERAGE FOR ANY PHYSICIAN, DOCTOR, SURGEON OR DENTIST.

15. Do practitioners carry their own professional liability coverage? ☐ YES ☐ NO
If YES, are you seeking entity coverage only? ☐ YES ☐ NO

16. Does the clinic perform any type of surgery? ☐ YES ☐ NO
If YES, please provide details:

_____

_____

17. Please provide the total number of patient or client visits per year:
Last 12 months _____ Next 12 months _____

18. Please provide the Organization's total gross revenue:
Last 12 months $_____ Next 12 months $_____

19. Please provide average billing per patient/client: $_____

20. Are any services performed outside of Canada or for patients/clients residing outside of Canada? ☐ YES ☐ NO
If YES, please provide details on a separate sheet.
What percentage of gross revenues are attributed to non-Canadian clients? _____ %

21. Does the Organization attract patients/clients because of reputation in any particular field? ☐ YES ☐ NO
If YES, please explain:

_____

_____

22. Does the Organization own, control or staff one or more of the following:
- Facilities for overnight care? ☐ YES ☐ NO
- Substance abuse program? ☐ YES ☐ NO
- Laboratory? ☐ YES ☐ NO
- Emergency vehicles? ☐ YES ☐ NO
- Pharmacy? ☐ YES ☐ NO

3. QUALITY CONTROL

23. Does the Organization have a written quality control program for care and services? ☐ YES ☐ NO
How are complaints handled?

24. Does the Organization provide for continuing education programs? ☐ YES ☐ NO

25. Is there any research or teaching activities being conducted? ☐ YES ☐ NO

26. How are qualifications of new staff checked?

27. Is proof of insurance required of subcontracted employees? ☐ YES ☐ NO
If NO, please explain:

28. If applicable, do you comply with the current guidelines for the safe handling, collection or disposal of dressings, surgical or clinical waste, sharps and of any blood or blood products? ☐ YES ☐ NO
If NO to any of the above, provide details:

29. How long are records kept?

30. Where and how are records kept?

4. PREVIOUS INSURANCE / CLAIM INFORMATION

31. During the last five (5) years, has the Organization carried Professional Liability insurance? ☐ YES ☐ NO
If YES, please complete the following for all previous policies:

INSURER	TERM	LIMIT	DEDUCTIBLE	PREMIUM

32. When was the first date on which the Organization purchased continuous claims made coverage?

33. Has the Organization or Principal(s) ever been declined, non-renewed or cancelled by any insurer for Professional Liability insurance? ☐ YES ☐ NO
If YES, please explain:

34. In the last five (5) years, has the Clinic ever had a claim made against it, or against any employee performing services for the Organization? ☐ YES ☐ NO
If YES, please provide the following details on a separate sheet:
1) Date of claim 2) Claimant's name 3) Nature of claim
4) Amount of indemnity payment and amount of defense costs 5) Final dispositions or current status of claim

35. Is the Organization, its partners, directors or officers aware of any situation or circumstance, which may reasonably result in a claim? ☐ YES ☐ NO
If YES, please describe in detail:

36. Has any practitioner/nurse or employee ever been investigated or suspended by any governing body? YES☐ NO ☐
If YES, please describe in detail.

For example, but not by way of limitation, an employment practices claim would result from a current or former employee's dissatisfaction with an employment relationship or application process by complaining of discrimination, harassment or unfair treatment.

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 therefrom is excluded from coverage under the proposed insurance.

5. NOTICE CONCERNING PERSONAL INFORMATION

By purchasing insurance from Beazley Canada Limited, a customer provides Beazley with his or her consent to the collection, use and disclosure of personal information, including that previously collected, for the following purposes:

- **the communication with underwriters;**
- **the underwriting of policies;**
- **the evaluation of claims;**
- **the detection and prevention of fraud;**
- **the analysis of business results;**
- **purposes required or authorized by law.**

For the purposes identified above, personal information may be disclosed to Beazley's related or affiliated companies and service providers.

Further information about Beazley's personal information protection policy may be obtained by contacting their privacy officer at 416-601-2155.

6. WARRANTY STATEMENT

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: _____ **DATED:** _____
(Authorized Representative)

NAME (Please Print): _____ **TITLE/POSITION:** _____