MEDICAL MALPRACTICE – INDIVIDUAL HEALTHCARE PROFESSIONALS APPLICATION

APPLICANT:

1. Name of Health Professional/Company (w. all subsidiaries)/Institution (Applicant):

Are they operating a franchise? ☐ YES ☐ NO

Address:

City: Province: Postal Code:

2. Web Site Address:
3. Branch Office locations:
4. Year Company was Established:

Is this a new company (company formed within the past 3 years)? ☐ YES ☐ NO

If YES, please attach the resume(s) of the principal(s)

5. Date of graduation/certification (principal employee):

a) Is the applicant currently enrolled as a student? ☐ YES ☐ NO

b) Are any of the employees currently enrolled as students? ☐ YES ☐ NO

c) In what capacity is the applicant and/or employees operating outside of the school or program? (i.e. performing services customers):

6. Number of Employees: Full-time - Cdn US Part-time - Cdn US
7. Are all Employees covered by W.C.B.? ☐ YES ☐ NO

If NO, please explain:

8. Does the Applicant/Company have locations or operations outside of Canada? ☐ YES ☐ NO

BUSINESS OPERATION:

9. Fees from Applicant's operations:

Last 12 months (expiring)	Next 12 months (estimates)
$	$

10. a) List all the business activities that coverage is being requested for. (please provide any brochures or list of services offered):

Activity	Percentage of income
	%
	%
	%

b) Does the Applicant sell any products? ☐ YES ☐ NO

If yes, estimated annual revenue $

c) Are any products imported? ☐ YES ☐ NO

If yes, from where?

11. Is the Applicant engaged in any business or profession other than described in 10 above? ☐ YES ☐ NO

a) Is the Applicant engaged in any teaching? ☐ YES ☐ NO

If yes, please name the activity/discipline, total number of students (annual), and gross total fees collected (annual):

12. Is the Applicant controlled, owned or associated with any other company, firm or corporation? ☐ YES ☐ NO
13. a) Is License required in order for the Applicant to practice? License # ☐ YES ☐ NO

b) Do all employees carry a valid license? ☐ YES ☐ NO

If no, please explain:

14. What professional association does the Applicant belong to?
15. Does the Applicant currently carry E&O or Medical Malpractice insurance through an association? ☐ YES ☐ NO

If yes, please name the association, limits of liability, insurer, and insurance broker:

16. Does the Application have a record of disciplinary action with the applicable professional association (including revocation or suspension of a license imposed by the licensing authority)? ☐ YES ☐ NO

If yes, please explain:

17. Does the Applicant use a written contract with clients? ☐ YES ☐ Majority of the Time ☐ NO

- If the Applicant subcontracts work, is proof of insurance required? ☐ YES ☐ NO

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18. Does the Applicant work with Professional Athletes? ☐ YES ☐ NO

19. These questions are only applicable to those involved in Home, Personal, and Respite Care:

    a. Is the Applicant a licensed nurse? ☐ YES ☐ NO

    b. Does the Applicant dispense medication? ☐ YES ☐ NO

    c. What type of clients are services being provided to:

    Adults with developmental disabilities ☐ YES ☐ NO Seniors ☐ YES ☐ NO

    Individuals under age of 16 ☐ YES ☐ NO Other ☐ YES ☐ NO If yes, please specify:

    d. Do you or any of your employees provide any manual handling/lifting services i.e. picking patients/residents up from their seats/beds etc.? If yes, please confirm the following: ☐ YES ☐ NO

        i. What training have the applicant or any of applicant's employees received?

        ii. How often are the employees retrained with manual handling / lifting services?

        iii. Is there a time where a client would require more than one person to assist? ☐ YES ☐ NO

        iv. Is there a manual handling / lifting services plan and/or safe patient handling program in place? ☐ YES ☐ NO

20. Do operations/services include laser vision correction: ☐ YES ☐ NO

21. This question is only applicable to those involved in 3D Imaging Ultrasound, Medical Ultrasound, and Sonographer:

    a. Are scans for medical diagnostic purposes ☐ YES ☐ NO

    b. Do you provide any diagnostic or any interpretation of the scans to anyone? ☐ YES ☐ NO

22. Do operations/services include those traditionally done by a midwife: ☐ YES ☐ NO

23. This question is only applicable to Dieticians and Nutritionists:

    a. Are recommendations made that exceed manufacturing or regulatory limits for dosage? ☐ YES ☐ NO

24. Do operations include the sale of medication on the internet? ☐ YES ☐ NO

25. These questions is only applicable to Veterinarians:

    a. Please state the largest value of animal that you perform services on: $

    b. Do you provide services to animals in commercial operations? ☐ YES ☐ NO

26. If laser treatment is performed, does this include tattoo removal? ☐ YES ☐ NO

27. If Microdermabrasion and/or Acid Peels are performed, please state maximum % of concentration used: %

28. These questions is only applicable to Counseling, Hypnotherapy, and Psychologists:

    a. Do you use Recovered/Regression Memory Therapy? ☐ YES ☐ NO

    b. Do you provide hypnosis services in a non-medical setting (i.e. entertainment or social purposes) ☐ YES ☐ NO

29. Details on all Partners and Directors:

Name	Professional Qualifications	Date Qualified	Years in Practice	Years as Partner

CLAIMS:

30. Has the Applicant/Company, its partners, directors, officers or employees ever had an order to cease & desist or a written demand or civil proceedings for compensatory damages made against them in past 5 years? ☐ YES ☐ NO

    If YES, please provide an explanation on a separate sheet: such as Date of claim, Claimant's name, Nature of claim, Amount of indemnity payment, Defense costs, Final dispositions or current status of claim.

31. Is the Applicant/Company, its partners, directors, officers or employees aware of any job disputes or fee disputes during the last five (5) years? ☐ YES ☐ NO

    If YES, please describe:

32. Is the Applicant/Company, its partners, directors, officers or employees aware of any other fact, situation or circumstance, that may result in a written demand or civil proceedings for compensatory damages? ☐ YES ☐ NO

    If YES, please describe in detail:

33. Has the Applicant/Company ever brought a claim or suit against another party? ☐ YES ☐ NO

    If YES, please describe:

34. Attach a list of all claims, disputes, suits or allegations of non-performance made during the past 5 years against the Applicant/Company or any director, officer, employee or partner (including any claims, disputes, suits or allegations of physical, mental or sexual abuse).

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PREVIOUS INSURANCE:

35. Has the Applicant/Company carried Errors and Omission Insurance in the past 5 years? ☐ YES ☐ NO

INSURER	TERM	LIMIT	PREMIUM	RETROACTIVE DATE

36. Has the Applicant ever had insurance refused or cancelled for this Company? ☐ YES ☐ NO

If YES, explain:

IT IS AGREED THAT IF THERE IS ANY KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY ARISING IT IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

ATTACHMENTS:

- ☐ Resumes of all Principals
- ☐ Standard Contract form, guarantee clauses
- ☐ Brochures or promotional materials
- ☐ Supplemental Application – Property Coverage

COVERAGE SUMMARY

Date Coverage required: **Target Premium $**

COVERAGE	Deductible	Limit of Coverage	Premium
Medical Malpractice: claims made form, costs inclusive	☐ $500 ☐ $1,000 ☐ $2,500 ☐ $	☐ $250,000/$250,000 ☐ $500,000/$500,000 ☐ $1,000,000/$1,000,000 ☐ $_____ / _____	
COMMERCIAL GENERAL LIABILITY: occurrence form -Bodily Injury and Property Damage, Products & Completed Operations, Personal Injury Liability, Medical Payments ($10,000)			
TENANT LEGAL LIABILITY: broad form ($250,000 Incl.)			
SPF6 – STANDARD NON-OWNED AUTOMOBILE:			

DECLARATION / CONSENT:

PLEASE READ BEFORE SIGNING: A claim will become invalid and the Insured's right of recovery is forfeited where (a) an Applicant for this contract gives false particulars to the prejudice of the insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein; or (b) the insured fails to inform material changes to these facts during the term of the contract; (c) the insured contravenes a term of the contract or commits a fraud; or (d) the insured willfully makes a false statement in respect of a claim.

The Applicants have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

The personal information provided in this document and in the future including, but not limited to, credit information and claims history may be collected, used and disclosed by the insured's representative or insurance company, subject to local legislation, for the purpose of communicating with the insured or their representative, assessing the application for insurance and underwriting any such policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

NOTE: Insurance is not in effect until Premier has issued a binder or policy documents.

Printed Name:	Date:
Position Held:	Applicant's Signature:
Brokerage:	Broker Name:
Broker Email:	Broker phone:

Premier Canada Assurance Managers Ltd. is one of Canada's largest Managing Underwriting Agents. The underwriting insurance carrier varies by line of business and region - please refer to specific quote for declaration of the underwriting insurance company(s).

**** Email application and attachments to - newbizprofessional@premiergroup.ca ****

Vancouver - T 604.669.5211 F 604.669.2667 **London - T 519.850.1610 F 519.850.1614**