PREMIER canada

MEDICAL MALPRACTICE – ALTERNATIVE THERAPISTS APPLICATION

APPLICANT:

1. Name of Applicant:

Address:

City: Province: Postal Code:

2. Web Site Address:

3. Have you registered with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia (CTCMA)? If yes, please provide information as below. ☐ YES ☐ NO

Date of Registration:	Registration No.:	Designation ☐ Dr. TCM ☐ R.TCM.P. ☐ R.Ac. ☐ R.TCM.H.

4. Details on all Applicants (please attach resumes/diplomas/certificates if any):

Name	Professional Qualifications	Date Qualified	Years of experience as TCM / Acupuncture Practitioners

5. Please check (√) therapies that you are qualified to provide

☐ Acupuncture	☐ Acupressure	☐ Allergy Testing
☐ Aroma Therapy	☐ Auriculotherapy	☐ Ayurveda
☐ Bio Feedback	☐ Chinese medicine	☐ Cupping
☐ Ear Candling	☐ First Aid	☐ Heat Therapy
☐ Holistic Counseling	☐ Homeopathy	☐ Iridology
☐ Magnetic Therapy	☐ Massage Therapy	☐ Moxibustion
☐ Naturopathy	☐ Nutrition Therapy	☐ Qi Gong
☐ Reflexology	☐ Reiki	☐ Shiatsu
☐ Skin Scrapping	☐ Spiritual Therapy	☐ Tai Chi
☐ Tapas Acupressure	☐ Therapeutic Touch	☐ Tuina
☐ Wu Head Massage	☐ Yoga	☐ Zen Therapy

Please provide details if your therapy does not appear in the above list.

6. Do you provide TCM/Acupuncture teaching or instructing? ☐ YES ☐ NO

If yes, please provide details.

Approx. No. of student per year	Approx. no. of hours per week	Estimate Annual Income from teaching

7. 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).

8. 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): ☐ YES ☐ NO

9. Number of Employees: Full-time - Cdn US Part-time - Cdn US

10. Does the Applicant have locations or operations outside of Canada? ☐ YES ☐ NO

BUSINESS OPERATION:

11. Fees from all of applicant's operations:

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

12. a) List all the business activities/specializations and duties performed 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?

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

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):

14. Do you work with children under the age of 16? ☐ YES ☐ NO

If yes, Please advise what age and under what circumstances:

15. Is the Applicant controlled, owned or associated with any other company, firm or corporation? ☐ YES ☐ NO

16. 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:

17. Does the Applicant currently carry E&O or Medical Malpractice insurance through the association? ☐ YES ☐ NO

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

18. Do you keep records for at least 7 years for all patients? ☐ YES ☐ NO

If no, please advise why the answer is NO.

19. Do you obtain satisfactory consent in writing from each patient prior to starting treatment? ☐ YES ☐ NO

If yes, please attach sample copy of consent form, intact form or client waiver.

20. Does the Applicant 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:

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

22. 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

23. Details on all Applicants (please attach resumes):

Name	Professional Qualifications	Date Qualified	Years in Practice	Years as Partner

CLAIMS:

24. 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.

25. 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:

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

If yes, please describe:

27. 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:

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

INSURER	TERM	LIMIT	PREMIUM	RETROACTIVE DATE

29. 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.

COVERAGE REQUIRED

COVERAGE	Deductible	Limit of Coverage	Premium
ONTARIO Medical Malpractice: claims made form, costs inclusive	$1,000	☐ $1,000,000 each claim /$5,000,000 Policy Aggregate ☐ $2,000,000 each claim /$5,000,000 Policy Aggregate ☐ $3,000,000 each claim /$5,000,000 Policy Aggregate ☐ $5,000,000 each claim /$5,000,000 Policy Aggregate	
ALL OTHER PROVINCES (excl. ONTARIO) Medical Malpractice: claims made form, costs inclusive	$500	☐ $1,000,000 each claim /$2,000,000 Policy Aggregate ☐ $1,000,000 each claim /$5,000,000 Policy Aggregate ☐ $2,000,000 each claim /$4,000,000 Policy Aggregate ☐ $2,000,000 each claim /$5,000,000 Policy Aggregate ☐ $3,000,000 each claim /$5,000,000 Policy Aggregate ☐ $5,000,000 each claim /$5,000,000 Policy Aggregate	

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 ****

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