# HEALTHCARE CLINICS / FACILITIES – MEDICAL MALPRACTICE AND CGL INSURANCE



## APPLICANT:

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

   _____

   Are they operating a franchise? ☐ YES ☐ No

   Address: _____

   City: _____ Province: _____ Postal Code: _____

2. Form of Business: ☐ Individual ☐ Corporation or Other Organization ☐ Partnership or Joint Venture

3. Web Site Address: _____

4. Branch Office locations: _____

5. 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).

6. a) Total Number of Salaried Employees:

| | Full-Time | Part-Time | | Full-Time | Part-Time |
|---|---|---|---|---|---|
| Physicians: | | | Registered Nurses(RNs): | | |
| Resident/Interns: | | | Nurse Practitioner (RN[EC]): | | |
| Diagnostic Technicians (X-Ray, MRI, CAT): | | | Registered Practical Nurses: (RPNs) | | |
| Lab/Path Technicians: | | | Allied Health Professional: (Please list) | | |
| Physician Assistants: | | | All other Employees: | | |

   b) Total Number of Independent Contractors (professionals that works at Applicant's business but are NOT employees):

   i) Physicians/Surgeons: Orthopedics: _____ Anesthesiologists: _____ Gynaecology: _____

   Urologists: _____ General Practitioners: _____

   Other Specialist (please list): _____

   ii) Allied Healthcare Professionals (please list number of each): _____

   c) Are all Employees covered by W.C.B.? ☐ YES ☐ NO

   If NO, please explain: _____

7. Accreditation:

   Is the Applicant an accredited facility? ☐ YES ☐ NO

   Accrediting Body: _____ Last Year Accreditation awarded: _____

8. a) List the name the discipline of every physician and surgeon working at the clinic and state the name of the Professional Liability insurer of each.

| Name | Professional Designation | Prior Insurer |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

   b) Complete the following for ALL employees not listed in question above. Use a separate sheet if necessary.

| Name | Services/Duties | Qualification/Education (include name of institution and if provincially regulated) | Years of Exp. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

   c) Are you now or have you, within the past five years, practiced subject to any restriction or limitation imposed upon your license? ☐ YES ☐ NO

   If yes, please provide details: _____

   d) Have you ever been disciplined by a licensing body? ☐ YES ☐ NO

   If yes, please provide details: _____

9. Annual Financial Information:

a) Current Financial Year Revenue: $ _____ Previous Financial Year Revenue: $ _____

b) What percentage of revenues/funds are generated from:

Government Funding: _____%

Private Funding: _____%

Charitable Donations: _____%

c) What percentage of Patients treated are:

Canadian Residents: _____% Non-Canadian Residents: _____%

d) Total Gross Assets: $ _____

10. a) Please indicate the number of visits/consultations/treatments/sessions during the past year: _____

b) Do you treat minors? ☐ YES ☐ NO

If yes, do you obtain written parental agreements? ☐ YES ☐ NO

11. 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. Does the Applicant/Company have locations, operations or employees outside of Canada ie US or other? ☐ YES ☐ NO

If yes, please provide details: _____

## BUSINESS OPERATION:

**13. Schedule of Services:**

| | | | |
|---|---|---|---|
| ☐ General Family Medicine | _____% | ☐ Pain Management Clinic | _____% |
| ☐ Homeopathic Clinic | _____% | ☐ Physiotherapy Clinic | _____% |
| ☐ Laser Clinic | _____% | ☐ Ultrasound Clinic | _____% |
| ☐ Naturopathic Clinic | _____% | ☐ X-Ray Clinic | _____% |
| ☐ Pathology Lab | _____% | ☐ Nursing Teaching Facility-Ray Clinic | _____% |
| ☐ Occupational Health Clinic | _____% | ☐ Medical Teaching Facility | _____% |

☐ Counselling Services *(Please specify list of services provided)* _____ _____%

**14. Define the type of facility:**

| | | % of Revenue | Annual # of Procedures |
|---|---|---|---|
| ☐ Surgical Centre: | ☐ Orthopedics<br>☐ Ophthalmology<br>☐ Plastic Surgery<br>☐ Gynaecology<br>☐ Gastro-Intestinal<br>☐ Hair Transplant<br>☐ Lap-Band Weight Loss | | |
| | ☐ Other (Please specify): _____ | | |
| ☐ Diagnostic Centre: | ☐ X-Ray<br>☐ CAT Scan<br>☐ MRI<br>☐ Blood Lab<br>☐ Colonoscopy<br>☐ Mammography | | |
| | ☐ Other (Please specify): _____ | | |
| ☐ Medical Clinic: | ☐ Primary General Practice<br>☐ Single Physician<br>☐ Multiple Physician<br>☐ Family Health Team<br>☐ Walk-in Clinic<br>☐ Fertility Clinic | | |

15. Please provide details of any new activities or developments that are likely to occur within the next 12 months (e.g. new construction projects or new clinical programs): _____

**16. Clinical Trials:**

Does the Applicant participate in Clinical Trials: ☐ YES ☐ NO

If yes, please complete the following questions:

a) Please state for whom Clinical Research Projects are undertaken (Trial Sponsors including Pharmaceutical Company, Research Foundations, etc.): _____

b) Do you receive full indemnity from the clinical trial sponsors? ☐ YES ☐ NO

c) Please provide annual revenue derived from Clinical Trial activity: $ _____

d) Please state the number of trials during the last 12 months detailing the number of volunteers in each trail: _____

e) Please state the anticipated number of trials with which the Applicant will be involved in during the next 12 months detailing the number of volunteers in each trial: _____

f) Informed Consent:

Do Volunteers sign an informed consent form? If Yes, please attach a copy to the application form. ☐ YES ☐ NO

Are double blind studies conducted and are volunteers clearly made aware of study format? ☐ YES ☐ NO

Do trials involve female volunteers of child-bearing age? ☐ YES ☐ NO

g) Does the Applicant conduct any formal research, testing or experimental activities in the following categories?

| | | | |
|---|---|---|---|
| Transplant | ☐ YES ☐ NO | Human Embryo Research | ☐ YES ☐ NO |
| Surgery | ☐ YES ☐ NO | Artificial Organ | ☐ YES ☐ NO |
| Obstetrics | ☐ YES ☐ NO | Genetic Engineering | ☐ YES ☐ NO |

**17. If Surgical Facility:**

Does the Applicant have a blood bank? ☐ YES ☐ NO

Does the Applicant undertake any testing of blood or blood products? ☐ YES ☐ NO

Is 100% of the blood or blood products secured from Canadian Blood Services? ☐ YES ☐ NO

Please state the average number of units of blood or blood products used by the Applicant annually:

_____

Please provide details on blood storage facilities and procedures: _____

**18. If Fertility Clinic:**

a) Please provide percentage (100%) breakdown of the number of cycles undertaken:

| | | | |
|---|---|---|---|
| A.I.H. | _____ % | Frozen Embryo Replacement | _____ % |
| A.I.D. | _____ % | GIFT | _____ % |
| IVF/ET/PROST | _____ % | | |

Others(please specify and indicate numbers): _____

b) Are counselling services available to patients? ☐ YES ☐ NO

c) Is all donor semen screened, cryo-preserved and quarantined in line with current best practices? ☐ YES ☐ NO

**19. If a Diagnostic Clinic:**

a) Estimate number of scan and/or images completed in a year? _____

b) Estimate number of obstetrical ultrasounds (fetal scans) in a year? _____

**20. If a Hair Transplant Facility:**

a) Please provide total number of procedures in a year: _____

b) Please provide the percentage breakdown between:

i) Follicular Unit Strip Surgery(FUSS): _____ %

ii) Follicular Unit Extraction (FUE): _____ %

iii) Scalp Reduction: _____ %

**21. If Home, Personal, and Respite Care:**

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

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

c) Do you or any of your employees provide any manual handling/lifting services ie. picking patients/residents up from their seats/beds etc.? ☐ YES ☐ NO

If yes, please confirm what training has been provided.

_____

_____

**22. If 3D Imaging Ultrasound, Medical Ultrasound, and Sonographer:**

a) Are scans for medical diagnostic purposes? ☐ YES ☐ NO

**23. If Dieticians and Nutritionists:**

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

**24. If Veterinarians:**

a) Please state the largest value of animal on which services are performed: $ _____

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

**25. If Counselling, Hypnotherapy, and Psychologists:**

a) Do you conduct 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

26. Has the Applicant:

a) Been involved in publishing any magazines, technical manuals, periodicals or bulletins? ☐ YES ☐ NO

b) On behalf of its stakeholders, engaged in advertising, broadcasting or reproduction of copyright? ☐ YES ☐ NO

c) Been involved in activities such as political lobbying or labour negotiations? ☐ YES ☐ NO

27. Does the Applicant:

a) Act as participant in a peer review group or committee for assessing the qualifications and performance of others? ☐ YES ☐ NO

b) Act as participant in a peer review group or committee for assessing the quality of products manufactured, sold, handled or distributed by others? ☐ YES ☐ NO

c) Carry out any disciplinary action or recommend disciplinary action as a result of peer review activities? ☐ YES ☐ NO

**28. Sub-contracted Services:**

a) What functions or facilities do you sub-contract: _____

| | | | |
|---|---|---|---|
| Nursing: | ☐ YES ☐ NO | Laundry: | ☐ YES ☐ NO |
| Cleaning: | ☐ YES ☐ NO | Road Maintenance: | ☐ YES ☐ NO |
| Meal Preparation: | ☐ YES ☐ NO | Landscaping/Lawn cutting: | ☐ YES ☐ NO |
| Security: | ☐ YES ☐ NO | Parking Garage or Lot Operation: | ☐ YES ☐ NO |
| Waste Disposal: | ☐ YES ☐ NO | Snow Removal: | ☐ YES ☐ NO |

Other: _____

b) Do all sub-contractors carry minimum $2,000,000 Commercial Insurance and add the applicant as an additional insured? ☐ YES ☐ NO

c) Do all contracts and/or third party agreements require review and approval by senior management? ☐ YES ☐ NO

If yes, who has the functional responsibility for approval?

Name and Title: _____

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

29. Are there any known contractual obligations where the Applicant has to provide insurance on behalf of another or hold another harmless? ☐ YES ☐ NO

If yes, please list all lease agreements, railway siding agreements, etc. & provide copies of agreements.

Are there any Additional Insureds to be added to the policy? ☐ YES ☐ NO

If yes, list and state purpose:

| Name | In Connection With |
|---|---|
| | |
| | |

30. Please give full details of where and how medical records are kept and for how long they are retained:

_____

_____

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

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

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

34. Please complete the following to the best of the Applicant's knowledge at the signing of the Application:

a) The governing body of the Applicant has a formal process for oversight of Risk Management that includes regular reports outlining the achievements of risk management. ☐ YES ☐ NO

If yes, please provide the latest report provided to the governing body and a brief description of the internal reporting process.

b) Procedures for incident reporting are clearly documented, disseminated and implemented throughout the Applicant's organization. ☐ YES ☐ NO

c) Medical record (electronic or paper) retention is in compliance with regulatory requirements. ☐ YES ☐ NO

d) Complaint management procedure is in place and appropriately reported to senior executives. ☐ YES ☐ NO

e) Formal mechanisms are in place for selection, recruitment, orientation and performance management of all employees and independent medical staff. ☐ YES ☐ NO

f) A formal mechanism is in place for medical staff credentialing, privilege declination and/or re-credentialing. ☐ YES ☐ NO

g) The Applicant is in compliance with all regulatory workplace health & safety requirements. ☐ YES ☐ NO

h) The Applicant disposes of all waste in accordance with regulatory requirements. ☐ YES ☐ NO

i) The Applicant sterilizes instruments in accordance with current best practice guidelines. ☐ YES ☐ NO

j) Applicant complies with manufacturer guidelines with respect to single-use products, devices or equipment. ☐ YES ☐ NO

## CLAIMS:

35. Has the Applicant/Company, its partners, 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 a full n explanation on a separate sheet: such as Date of claim, Claimant's name etc.

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

If yes, please describe: _____

37. Is the Applicant/Company, its partners, 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: _____

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

If yes, please describe: _____

39. 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 employee or partner.

## PREVIOUS INSURANCE:

40. Has the Applicant / Company carried Medical Malpractice Insurance in the past 5 years? ☐ YES ☐ NO

| INSURER | TERM | LIMIT | PREMIUM | RETROACTIVE DATE |
|---|---|---|---|---|
| | | $ | $ | |
| | | $ | $ | |
| | | $ | $ | |
| | | $ | $ | |
| | | $ | $ | |

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

If yes, please explain: _____

## COVERAGE REQUIREMENTS:

| Coverage | Deductible | Limit of Coverage | Target Premium |
|---|---|---|---|
| MEDICAL MALPRACTICE: claims made form, costs incl | ☐ $500<br>☐ $1,000<br>☐ $2,500 | ☐ $250,000/$250,000<br>☐ $500,000/$500,000<br>☐ $1,000,000/$1,000,00 | |
| COMMERCIAL GENERAL LIABILITY: occurrence form<br>-Bodily Injury & Property Damage, Products & Completed Operations, Personal Injury Liability, Medical Payments ($10,000), $100,000 Sexual Abuse Cover | | | |
| TENANT LEGAL LIABILITY: broad form ($250,000 Incl.) | | | |
| SPF6 – STANDARD NON-OWNED AUTOMOBILE: | | | |
| **Optional Property Coverage is available. Please complete Healthcare Clinics Supplemental Property Application** | | | |

## 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.**

| | |
|---|---|
| **Applicant Name:** | **Position Held:** |
| **Applicant Signature:** | **Date:** |
| **Brokerage Email:** | **Broker Name/Number:** |

*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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