APPLICATION

Medical Malpractice

RISKCAN Underwriting Managers

SECTION 1: APPLICANT INFORMATION

1. Full Name of all Entities to be insured (including service, administrative or nominee companies and subsidiaries to be covered by this policy):

_____

2. Mailing Address: _____
3. Address(es) of branch offices or other locations: _____
4. Business Phone: _____ Cell Phone: _____
5. Email: _____ Website: _____
6. Practice Inception Date (mm/dd/yyyy): _____
7. Additional Insured & Address: _____

SECTION 2: UNDERWRITING INFORMATION

1. Please supply the following details:

Name of Partners, Principals and Directors	Age	Qualifications	Date Qualified	Period Practicing as Partner, Principal or Director	
				This Practice	Previous Practice

2. Please supply total numbers of:
   a. Partners/Principals/Directors: _____
   b. Qualified Staff: _____
   c. Other Technical Staff: _____
   d. Trainee Staff: _____
   e. Non-technical Administrative Staff: _____
   f. Clerical Staff: _____
   g. Other Staff (please specify): _____

   Total Staff: _____

For Sole Proprietors Only - Questions 3 and 4

3. State the experience of your assistants and their length of service and/or any training provided.

_____

4. What arrangements do you have to assist you during a temporary absence on business, leave, sickness, or unforeseen emergency?

5. Has the name of the practice ever been changed? ◯ Yes ◯ No
   Has any other practice or business amalgamated or merged with you? ◯ Yes ◯ No
   Have you purchased any other practice or business? ◯ Yes ◯ No
   If yes to any of the above, please provide details:

6. Is any partner, principal or director connected or associated (financially or otherwise) with any other practice or business? ◯ Yes ◯ No
   If yes, please provide details:

7. Please list the professional bodies or associations to which you belong:

8. Please detail your fee income:
   for the last 12 months: _____ estimated for the next 12 months: _____

9. Please provide an approximate percentage split of your fee income derived from the following fields of work:

Type of Work	%	Type of Work	%
Acupuncture		Chiropractic	
Audiology		Massage	
Optometry		Nutrition/Dietetics	
Beauty Therapy/Aesthetics		Pathology	
Hair & Scalp Treatment		Clinic Research	
Chiropody		Physiotherapy	
Podiatry		Psychology	
Chemical/Pharmaceutical		Speech Therapy	
Dentistry/Orthodontics		Occupational Therapy	
Home Nursing		Naturopathy	
Osteopathy		Other (complete question 10)	
		TOTAL	**100%**

10. Complete if applicable:
    a. Please provide details of the precise nature of activities or business:

    b. Please provide details of any advice given and/or your informed consent procedures in relation to the activities or business outlined above:

    c. Are verbal reports always confirmed in writing? ◯ Yes ◯ No

    If no, how do you substantiate such verbal reports?

11. Does any contract or client represent more than 50% of your annual work of fees? ◯ Yes ◯ No
12. Do you engage consultants, sub-contractors or agents? ◯ Yes ◯ No

    If yes:

    a. Do you insist they carry their own professional indemnity or malpractice insurance? ◯ Yes ◯ No
    b. Do you enter into any hold-harmless agreements or otherwise waive any legal rights or entitlements which you may have against such consultants, sub-contractors or agents? ◯ Yes ◯ No
13. Do you envisage any substantial changes in your activities or are there any major new operations contemplated during the next 12 months? ◯ Yes ◯ No

    If yes, please provide details:

14. Do you perform work outside of your country of domicile or work for clients located overseas? ◯ Yes ◯ No

    If yes, please provide details:

SECTION 3: INSURANCE & LOSS HISTORY INFORMATION

1. Does the Practice presently carry, or has the Practice ever carried, malpractice liability insurance? ◯ Yes ◯ No

   If yes, please supply details:

   Previous Insurer: _____ Policy #: _____

   Expiring Premium: _____ Expiry Date: _____

   Limit of Indemnity: _____
2. Has the Practice or any partner, principal or director ever been refused this type of insurance, or had similar insurance canceled, or had an application renewal declined, or had special terms imposed? ◯ Yes ◯ No

   If yes, please provide details:

3. Limit of Indemnity Required: _____

4. Deductible/Excess Requested (applicable to every claim): _____

5. Are you aware of any incident which may result in a claim against you? ◯ Yes ◯ No

   If yes, please provide details:

   _____

6. Has any partner, principal, director or staff member ever been subject to disciplinary proceeding for professional misconduct? ◯ Yes ◯ No

   If yes, please provide details:

   _____

7. Have any claims for negligence or breach of professional duty been made in the last ten (10) years against you or your practice or any of its predecessors in business or any prior practice of any of your present or former partners, principals or directors? ◯ Yes ◯ No

   If yes, please provide details:

   _____

SECTION 4: DECLARATION

It is understood and agreed that the completion of this application shall not be binding either to the proposed insured or to Risk-Can Underwriting Managers until accepted by Risk-Can Underwriting Managers, but that the information contained herein shall be the basis of the contract should a policy be issued.

I declare that the statements made in this application are complete and true to the best of my knowledge. I understand that the Application Form will form part of the insurance policy. I acknowledge that if, at any time of claim, it is discovered that any question in this application is not answered truthfully, accurately and completely, it may result in the non-payment of any claim and/or my coverage will be made null and void.

Your privacy is protected: The insurance coverage you are applying for is provided to you by Risk-Can Underwriting Managers and Risk-Can Underwriting Managers will collect, use and disclose the personal information, which you give, for the purpose of providing you with insurance services. Your information may be disclosed to others in the credit services, investigative and/or insurance fields as necessary to underwrite and administer this insurance and to pay any benefits.

_____ _____

Applicant's Name (Please print) Title/Position

_____ _____

Signature of Applicant Date (MM/DD/YYYY)

BROKER CONTACT INFORMATION

Agent Name: _____ Brokerage Name: _____

Email: _____ Address: _____

Phone: _____ City / Province: _____

Fax: _____ Postal Code: _____