

**Toronto Office:** 18 King St. E., Suite 903 Toronto, ON M5C 1C4  
T: 416-603-7864 or 1-877-603-7864 | F: 416-603-7861 | www.suminsurance.ca

**Montreal Office:** 1001 De Maisonneuve Blvd. W., Suite 900 Montreal, QC H3A 3C8  
T: 514-845-7861 or 1-855-845-7861 | F: 514-844-7862 | www.assurancesum.ca

---

## APPLICATION – MEDICAL MALPRACTICE INSURANCE

---

### COMPLIMENTARY MEDICAL PRACTITIONERS

Full Name of the Applicant: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Trading Name (if different from above): \_\_\_\_\_

Has the applicant ever engaged in a similar activity under a different name?

Yes  No If Yes, please provide details: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_

Practice / Trading address/es: \_\_\_\_\_  
(if different from above) \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

If cover is required for more than one location, please attach a list of all addresses.

1. A) WHAT IS THE APPLICANT’S TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS?

(If new business please state estimated income for the forthcoming 12 months). **This question must be answered.**

\$ \_\_\_\_\_

B) TOTAL NUMBER OF TREATMENTS / SESSIONS / CONSULTATIONS?

2. DOES THE APPLICANT WORK AS AN INDIVIDUAL PRACTITIONER/THERAPIST?  Yes  No

3. A) IN WHAT BRANCH OR BRANCHES OF COMPLEMENTARY MEDICINE IS THE APPLICANT QUALIFIED AND, IF APPLICABLE, LICENSED TO PRACTISE?

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Craniosacral Therapy	<input type="checkbox"/> Neuro-linguistic-programming
<input type="checkbox"/> Acupressure	<input type="checkbox"/> Healing/Reiki	<input type="checkbox"/> Nutrition Therapy
<input type="checkbox"/> Allergy Testing	<input type="checkbox"/> Herbalism	<input type="checkbox"/> On Site Massage
<input type="checkbox"/> Alexander Technique	<input type="checkbox"/> Hypnotherapy	<input type="checkbox"/> Polarity Therapy
<input type="checkbox"/> Aromatherapy	<input type="checkbox"/> Indian Head Massage	<input type="checkbox"/> Psychology
<input type="checkbox"/> Ayurveda	<input type="checkbox"/> Iridology	<input type="checkbox"/> Radionics
<input type="checkbox"/> Bach Remedies	<input type="checkbox"/> Kinesiology	<input type="checkbox"/> Reflexology
<input type="checkbox"/> Bates Method	<input type="checkbox"/> Light Touch Therapy	<input type="checkbox"/> Rolfing
<input type="checkbox"/> Colonic Irrigation	<input type="checkbox"/> Massage	<input type="checkbox"/> Sports Massage
<input type="checkbox"/> Colour Therapy	<input type="checkbox"/> Moxibustion	<input type="checkbox"/> Stress Counselling
<input type="checkbox"/> Counselling	<input type="checkbox"/> Music Therapy	<input type="checkbox"/> Touch for Health
<input type="checkbox"/> Crystal Therapy	<input type="checkbox"/> Naturopathy	<input type="checkbox"/> Yoga
Other (please specify):		

B) WHERE AND WHEN DID THE APPLICANT QUALIFY?

\_\_\_\_\_

Please provide a copy of their Certificates / Diplomas with the application

4. PLEASE GIVE FULL DETAILS OF WHAT PATIENT RECORDS ARE KEPT, WHERE AND HOW THEY ARE STORED AND FOR HOW LONG THEY ARE RETAINED:

\_\_\_\_\_

\_\_\_\_\_

Please note it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

5. PLEASE STATE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE APPLICANT'S WORK BETWEEN THE FOLLOWING CATEGORIES AND STATE WHETHER THE APPLICANT IS EMPLOYED OR SELF-EMPLOYED:

	EMPLOYED	SELF-EMPLOYED
The Applicant's Private Practice	%	%
Clinics	%	%
Private Non-Surgical Nursing Homes and Hospices	%	%
Patients' Homes	%	%
Other (please specify) _____	%	%

If the applicant is an employee, please state the name of the company (or other entity) for whom they work:

6. HAS THE APPLICANT OR ANY EMPLOYEE INVOLVED IN THE TREATMENT OR CARE OF PATIENTS BEEN THE SUBJECT OF OR CONVICTED OF ANY CRIMINAL OFFENCE (OTHER THAN MINOR TRAFFIC OFFENCES), PROFESSIONAL DISCIPLINARY PROCEEDINGS OR INQUIRIES?

Yes    No   If Yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. A) IS THE APPLICANT A MEMBER OF ANY PROFESSIONAL ORGANIZATION, OR REGISTERED WITH ANY SELF REGULATING BODY?

Yes    No   If Yes, please state which and period of membership / registration: \_\_\_\_\_  
 \_\_\_\_\_

B) HAS MEMBERSHIP OR REGISTRATION WITH SUCH ORGANIZATION/BODY EVER BEEN SUSPENDED, WITHDRAWN, AMENDED OR DECLINED OR HAD CONDITIONS ATTACHED?    Yes    No

8. IF THE APPLICANT IS AN EMPLOYEE, IS IT A CONDITION OF THEIR EMPLOYMENT THAT THEY MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE?    Yes    No

9. HAS THE APPLICANT PREVIOUSLY INSURED FOR MEDICAL PROFESSIONAL LIABILITY?

Yes  No If Yes, please provide:

Name of insurer: \_\_\_\_\_

Date the Policy expires: \_\_\_\_\_ Limit of Liability: \_\_\_\_\_

Deductible: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_

Basis of cover (claims made or occurrence based): \_\_\_\_\_

If No, please provide details: \_\_\_\_\_

\_\_\_\_\_

10. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS?  Yes  No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER?  Yes  No

**If the answer to either 10 a) or 10 b) is Yes, complete the enclosed CLAIMS HISTORY FORM.**

**Note:** THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 10 A) AND/OR 10 B) OR ANY ERROR, ACT, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

11. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENSE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

Yes  No If Yes, please provide details: \_\_\_\_\_

12. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE, FOR THE APPLICANT, ANY PRESENT PARTNER OR OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS?

Yes  No If Yes, please provide details: \_\_\_\_\_

13. WHEN IS THE APPLICANT'S FISCAL YEAR END? \_\_\_\_\_

14. INSURANCE REQUIRED:

LIMITS:

- \$250,000/\$500,000
- \$500,000/\$1,000,000
- \$1,000,000/\$1,000,000
- \$1,000,000/\$2,000,000
- \$2,000,000/\$2,000,000
- \$3,000,000/\$3,000,000
- \$4,000,000/\$4,000,000
- \$5,000,000/\$5,000,000
- Other \_\_\_\_\_

DEDUCTIBLE

- \$2,500(Min.)
- \$5,000
- \$10,000
- \$25,000
- \$50,000
- Other \_\_\_\_\_

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this declaration does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 10 a) or 10 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: \_\_\_\_\_ Dated: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

BROKER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE NO: \_\_\_\_\_

FAX NO: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_



**Toronto Office:** 18 King St. E., Suite 903 Toronto, ON M5C 1C4  
T: 416-603-7864 or 1-877-603-7864 | F: 416-603-7861 | [www.suminsurance.ca](http://www.suminsurance.ca)

**Montreal Office:** 1001 De Maisonneuve Blvd. W., Suite 900 Montreal, QC H3A 3C8  
T: 514-845-7861 or 1-855-845-7861 | F: 514-844-7862 | [www.assurancesum.ca](http://www.assurancesum.ca)

## ADDENDUM 1

TO BE COMPLETED IF NOT AN INDIVIDUAL PRACTITIONER/THERAPIST

1. NUMBER OF QUALIFIED PRACTITIONERS / THERAPISTS? \_\_\_\_\_

2. DETAILS OF DIRECTORS / PARTNERS / PRACTITIONERS / THERAPISTS

NAME	QUALIFICATIONS / EXPERIENCE DETAILS	EMPLOYED OR SELF EMPLOYED

3. PLEASE PROVIDE FULL DETAILS OF ANY EQUIPMENT USED TO PERFORM TREATMENT OR THERAPY (ON A SEPARATE SHEET OF PAPER OR USE THE SPACE BELOW) AND ATTACH ANY RELEVANT BROCHURE.

---

---

---

---

---

4. PLEASE PROVIDE DETAILS OF ALL INFORMATION GIVEN OUT I.E. BROCHURES AND LITERATURE.

5. PLEASE LIST ADDRESSES OF EACH LOCATION THE APPLICANT OPERATES FROM (ON A SEPARATE SHEET OF PAPER OR USE THE SPACE BELOW).

6. A) DOES THE APPLICANT SUBCONTRACT ANY WORK OUT?

Yes    No   If Yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

B) WHAT LIMIT OF LIABILITY DOES THE APPLICANT REQUIRE THEIR SUB CONTRACTORS TO INSURE FOR?

\$ \_\_\_\_\_

7. PLEASE PROVIDE A COPY OF THE APPLICANT'S STANDARD FORM OF AGREEMENT / CONTRACT OR LETTER OF APPOINTMENT

PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE APPROPRIATE QUESTION NUMBER.



# CLAIMS HISTORY FORM

Applicant Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Claimant Name:** \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Description of Claim:

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
LOSS RESERVES	\$
EXPENSE RESERVES	\$
LOSS PAID	\$
EXPENSES PAID	\$

**Claimant Name:** \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Description of Claim:

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
LOSS RESERVES	\$
EXPENSE RESERVES	\$
LOSS PAID	\$
EXPENSES PAID	\$

**Claimant Name:** \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Description of Claim:

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
LOSS RESERVES	\$
EXPENSE RESERVES	\$
LOSS PAID	\$
EXPENSES PAID	\$

**Claimant Name:** \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Description of Claim:

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
LOSS RESERVES	\$
EXPENSE RESERVES	\$
LOSS PAID	\$
EXPENSES PAID	\$

**Claimant Name:** \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Description of Claim:

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
LOSS RESERVES	\$
EXPENSE RESERVES	\$
LOSS PAID	\$
EXPENSES PAID	\$