SAVE

GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

Toronto Office: 18 King St. E., Suite 903 Toronto, ON M5C 1C4
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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?

☐ Acupuncture	☐ Craniosacral Therapy	☐ Neuro-linguistic-programming
☐ Acupressure	☐ Healing/Reiki	☐ Nutrition Therapy
☐ Allergy Testing	☐ Herbalism	☐ On Site Massage
☐ Alexander Technique	☐ Hypnotherapy	☐ Polarity Therapy
☐ Aromatherapy	☐ Indian Head Massage	☐ Psychology
☐ Ayurveda	☐ Iridology	☐ Radionics
☐ Bach Remedies	☐ Kinesology	☐ Reflexology
☐ Bates Method	☐ Light Touch Therapy	☐ Rolfing
☐ Colonic Irrigation	☐ Massage	☐ Sports Massage
☐ Colour Therapy	☐ Moxibustion	☐ Stress Counselling
☐ Counselling	☐ Music Therapy	☐ Touch for Health
☐ Crystal Therapy	☐ Naturopathy	☐ 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:	DEDUCTIBLE
☐ $250,000/$500,000	☐ $2,500(Min.)
☐ $500,000/$1,000,000	☐ $5,000
☐ $1,000,000/$1,000,000	☐ $10,000
☐ $1,000,000/$2,000,000	☐ $25,000
☐ $2,000,000/$2,000,000	☐ $50,000
☐ $3,000,000/$3,000,000	☐ Other _____
☐ $4,000,000/$4,000,000	
☐ $5,000,000/$5,000,000	
☐ 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: _____

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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 THESPACE 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 ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Date of Loss: ______________________________

Description of Claim:

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Date of Loss: ______________________________

Description of Claim:

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Date of Loss: ______________________________

Description of Claim:

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Date of Loss: ______________________________

Description of Claim:

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$