SAVE

GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

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: 625 President-Kennedy Avenue, Suite 903 Montreal, QC H3A 1K2
T: 514-845-7861 or 1-855-845-7861 | F : 514-844-7862 | www.assurancesum.ca

APPLICATION – **MEDICAL MALPRACTICE INSURANCE**

REGISTERED SUPPLEMENTARY MEDICAL PRACTITIONERS

Full Name of the Applicant: _____

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)) AT WHICH SCHOOL DID THE APPLICANT GRADUATE?

_____

B) IN WHAT YEAR? _____

C) DEGREE OBTAINED? _____

Please give details of any additional or post graduate qualifications: _____

_____

2. IN WHAT CAPACITY IS THE APPLICANT QUALIFIED OR LICENSED TO PRACTICE?

☐ Audiologist
☐ Chiropodist
☐ Chiropractor
☐ Dietician
☐ First Aider
☐ Medical Lab technician
☐ Midwife
☐ Nurse
☐ Nurse Aesthetician
☐ Nurse Anesthetist
☐ Occupational Therapist
☐ Osteopath
☐ Paramedic
☐ Perfusionist
☐ Pharmacist
☐ Physiotherapist
☐ Podiatrist
☐ Prosthetist / Orthotist
☐ Radiographer
☐ Sonographer
☐ Speech Therapist
☐ Surgical
☐ Optometrist/Optician
☐ Other (please specify): _____

If you practice as a Midwife:

a) Please state the number of:

i) Emergency non hospital births you attended in the last 12 months: _____

ii) Routine home births you attended in the last 12 months: _____

b) Please give full details of any back-up hospital arrangements: _____

_____

3. PLEASE GIVE FULL DETAILS OF WHAT PATIENT RECORDS ARE KEPT, WHERE & 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.

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

CATEGORY	EMPLOYED	SELF-EMPLOYED
The Applicant's Private Practice	%	%
Public Sector Hospitals / Homes	%	%
Private Surgical Hospitals / Homes	%	%
Private Non-Surgical Homes	%	%
Patients' Homes	%	%
Other (please specify) _____	%	%
Total	0 %	0 %

If the applicant is an employee, please state the name of the employing authority or the name of the private hospital or company for which they work.

_____

_____

5. WHAT IS YOUR TOTAL GROSS ANNUAL INCOME (EXCLUDING INCOME FROM THE SALE OF GOODS) FOR THE WORK YOU ARE PROPOSING TO INSURE? (If new business please state estimated income for the forthcoming 12 months) $_____

6. DOES THE APPLICANT OWN (WHOLLY OR IN PART), OPERATE OR ADMINISTER ANY HOSPITAL, NURSING HOME OR ANY OTHER MEDICAL ESTABLISHMENT? ☐Yes ☐No

If the answer is Yes, an additional proposal form will have to be completed before quotations can be given.

7. PLEASE STATE THE NUMBER OF STAFF AND GIVE DETAILS OF THE CAPACITY IN WHICH THEY PRACTICE:

_____

_____

8. A) DOES THE APPLICANT OR ANY MEMBER OF STAFF INVOLVED IN THE TREATMENT OR CARE OF PATIENTS SUFFER FROM ANY DISABILITY, TRANSMITTABLE DISEASES (I.E. HEPATITIS, H.I.V. ETC.), OR OTHER IMPEDIMENT WHICH MAY AFFECT THE PERFORMANCE OF HIS OR HER PROFESSIONAL DUTIES OR PLACE PATIENTS AT RISK?

☐Yes ☐No If Yes, what procedures are in place?_____

_____

B) HAS THE APPLICANT OR ANY MEMBER OF STAFF 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 give full details: _____

_____

_____

_____

9. 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:_____

_____

Has membership of / registration with such organization / body ever been suspended, withdrawn, amended or declined or had conditions attached? ☐ Yes ☐ No

10. IF THE APPLICANT IS AN EMPLOYEE, IS IT A CONDITION OF THEIR EMPLOYMENT THAT THEY MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE OR THAT THEY BE A MEMBER OF ANY DEFENCE ORGANIZATION?

☐ Yes ☐ No If Yes, please provide full details:_____

_____

11. HAS THE APPLICANT PREVIOUSLY INSURED FOR 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: _____

_____

_____

12. 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 12 A) or 12 B) is Yes, complete the enclosed CLAIMS HISTORY FORM.

Note: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 12 A) AND/OR 12 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

13. 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: _____

_____

14. 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: _____

_____

15. 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 12 a) or 12 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: _____

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	$