



106 FRONT STREET, EAST, SUITE 303 TORONTO, ON M5A 1E1
 MAIN: 416-477-2353 FAX: 416-477-2399

Professional and General Liability Insurance Application for Individual Regulated & Allied Healthcare Personnel

For the purpose of the Insurance Companies Act (Canada), this document was issued in the course of Lloyd's Underwriters' insurance business in Canada.

This application form is designed exclusively for completion by individual regulated & allied healthcare personnel who do not employ staff.

Please read and complete the application in its entirety. Blanks &/or dashes are not acceptable and will delay consideration of this application. Answer all questions, if the question does not apply, indicate "N/A" in the circle provided.

Return the completed application to MedThree Insurance Group.

SECTION 1 – GENERAL INFORMATION

1. Name (Please print):											
Trading Name if different from the above:											
2. Address:				Is this your residence?				<input type="checkbox"/> Yes		<input type="checkbox"/> No	
City/Town:			Province:			Postal Code:					
Phone No.:			E-Mail:								
3. Practice Address if different from the above:											
City/Town:			Province:			Postal Code:					
Phone No.:			E-Mail:								
4. Are you a current policy holder or a new applicant?						<input type="checkbox"/> Existing Holder		<input type="checkbox"/> New Applicant			
5. Describe your employment status:						<input type="checkbox"/> self-employed/independent contractor <input type="checkbox"/> employed practitioner <input type="checkbox"/> contract employee <input type="checkbox"/> student					
6. If you are an employee, provide the name of your employer:											
7. If you are self-employed, what is the legal structure of your business:						<input type="checkbox"/> sole proprietorship <input type="checkbox"/> corporation <input type="checkbox"/> professional corporation (Ontario only) <input type="checkbox"/> partnership					
8. Do you own or operate a healthcare entity?						<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, the name of the entity is:											
Contact Name:			Telephone No.:								
Email Address:			Year Established:								

If you own or operate a healthcare establishment, you must complete MedThree's Healthcare Establishment Application before quotations can be given.

9. Please state your gross annual revenue excluding revenue from the sale of goods in respect of the following years (in CAD):		Last Year:	\$	This year:	\$
--	--	------------	----	------------	----

SECTION 2 – PROFESSIONAL PRACTICE

PART A – REGULATED HEALTHCARE PROFESSIONALS

1. In what capacity are you licensed to practice?					
Audiologist	<input type="checkbox"/>	Medical Radiation Technologist	<input type="checkbox"/>	Podiatrist	<input type="checkbox"/>
Chiropodist	<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>	Psychologist	<input type="checkbox"/>
Dental Hygienist	<input type="checkbox"/>	Optician	<input type="checkbox"/>	Psychotherapist	<input type="checkbox"/>
Dental Technologist	<input type="checkbox"/>	Optometrist	<input type="checkbox"/>	Registered Nurse	<input type="checkbox"/>
Denturist	<input type="checkbox"/>	Pharmacist	<input type="checkbox"/>	Registered Practice Nurse	<input type="checkbox"/>

Dietitian	<input type="checkbox"/>	Pharmacy Technician	<input type="checkbox"/>	Respiratory Therapist	<input type="checkbox"/>
Kinesiologist	<input type="checkbox"/>	Nurse Practitioner	<input type="checkbox"/>	Speech-language Pathologist	<input type="checkbox"/>
Medical Laboratory Technologist	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>		

2. Number of years in practice: _____

3. Are you a member of an applicable professional association? Yes No N/A

If yes, please list membership affiliations: _____

4. Are you accredited and/or certified? Yes No N/A

If yes, please list accreditations and/or certifications: _____

PART B – Allied Healthcare Personnel

1. In what capacity are you licensed to practice?

Alcohol & Drug Counsellor	<input type="checkbox"/>	Medical Technician	<input type="checkbox"/>	Recreation Therapist	<input type="checkbox"/>
Ambulance Attendant (non-paramedic)	<input type="checkbox"/>	Mental Health Counsellor	<input type="checkbox"/>	Rehabilitation Counsellor or Therapist	<input type="checkbox"/>
Attendant	<input type="checkbox"/>	Music Therapist	<input type="checkbox"/>	Respiratory Therapy Technician	<input type="checkbox"/>
Care Aide	<input type="checkbox"/>	Occupational Therapy Assistant	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
Dental Assistant	<input type="checkbox"/>	Orthopedic Assistant	<input type="checkbox"/>	Sports Medicine Instructor	<input type="checkbox"/>
Dialysis Technician	<input type="checkbox"/>	Orthoptist	<input type="checkbox"/>	Surgical Technician	<input type="checkbox"/>
Dietary (Nutritionist)	<input type="checkbox"/>	Personal Support Worker	<input type="checkbox"/>	Wellness Counsellor	<input type="checkbox"/>
Consultant	<input type="checkbox"/>	Pharmacy Technician/Assistant	<input type="checkbox"/>	Other (Please specify):	<input type="checkbox"/>
Fitness Professional	<input type="checkbox"/>	Plebotomist	<input type="checkbox"/>		
Healthcare Counsellor	<input type="checkbox"/>	Physiotherapy Aide/Assistant	<input type="checkbox"/>		
Hearing Aid Fitter	<input type="checkbox"/>	Podiatry Assistant	<input type="checkbox"/>		
Laboratory Technician	<input type="checkbox"/>				

2. Number of years in practice: _____

3. Are you a member of an applicable professional association? Yes No N/A

If yes, please list membership affiliations: _____

4. Are you accredited and/or certified? Yes No N/A

If yes, please list accreditations and/or certifications: _____

SECTION 3 – INSURANCE COVERAGE REQUIRED

1. Please select the type(s) of coverage you wish to purchase and the limit desired for each coverage:

Type of Coverage		Limit \$1 Million	Limit \$2 Million	Limit \$5 Million
Professional Medical Malpractice (Claims Made)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Commercial General Liability (Occurrence)	<input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 4 – GENERAL LIABILITY – THIS POLICY IS ON AN OCCURRENCE BASIS

1. Complete a brief description of your premises in the table below:

Name of Building	Location	Year Built	Size (sq.ft.)	# of Storeys

2. Do you require coverage on any business/entity that you own or control? Yes No N/A

3. Please list any premises' function or facilities that you sub-contract (e.g., cleaning, waste disposal, etc.): _____

4. Do you require sub-contractors to carry adequate insurance and name your establishment as an additional insured to their insurance? Yes No N/A

5. Do the premises comply with current fire protection and prevention requirements? Yes No N/A

6. Are you aware of what to do in the event of fire or other emergency?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7. Do the premises have an emergency back-up system (e.g., for lighting, fire protection)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8. Are facilities for safe collection, storage and disposal of bio-medical waste provided in accordance with current guidelines/legislation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

SECTION 5 – – PROFESSIONAL LIABILITY SECTION – THIS POLICY SECTION IS ON A CLAIMS MADE BASIS

1. Is informed consent obtained prior to all procedures/tests etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. Are there written procedures for you to handle medical emergencies (e.g., anaphylaxis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3. Are you certified in Basic Life Support?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. Do you follow Health Canada and applicable provincial guidance for infection control including the reprocessing of reusable medical equipment and devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. Are you trained on all equipment you use in your practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6. Does all equipment utilized in your practice undergo periodic inspection, testing, and preventive maintenance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7. Are records of inspection, maintenance, testing and calibration of equipment kept?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8. Are clinical records retained for a least ten (10) years from the date of the patient/client's last visit, and in the case of minors, for at least ten (10) years after that minor attains majority?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
9. Are measures in place for the protection of patient/client health information in compliance with relevant privacy legislation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
10. Do you product or supply products?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
11. Do you fit or alter products such as wheelchairs and like devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

SECTION 6 – CLAIMS AND INSURANCE HISTORY

A. Claims

1. Have any negligence claims ever been made against you whether successful or otherwise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have any claims for dishonesty ever been made against you whether successful or otherwise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have a record of disciplinary action with your professional association, including revocation or suspension of your license by the governing body of your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been convicted of violating any law, except a minor traffic offence, as a result of your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have any sexual harassment and/or abuse claims ever been made against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Please list all claims and incidents that may result in a claim, prior to the effective date of this proposed policy, which would have given rise to a claim, arising from your professional activities in the past year. If none, state "none":

<i>Year of Incident</i>	<i>Nature of Injuries</i>	<i>Injured Party</i>

B. Insurance History

1. Have you ever been declined, cancelled or non-renewed by an insurance for Professional Liability Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been cancelled for non-payment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has prior coverage been a Claims Made Basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If claims made, most recent retroactive date (mm/dd/yyyy):

<i>Previous Insurer</i>	<i>Policy No</i>	<i>Liability Limits</i>	<i>Premium</i>	<i>Expiry Date (mm/dd/yyyy)</i>

NOTICE CONCERNING PERSONAL INFORMATION

By purchasing insurance from Medthree Insurance Group, a customer provides Medthree Insurance with his or her consent to the collection, use and disclosure of personal information, including that previously collected, for the following purposes:

- the communication with underwriters;
- the underwriting of policies;
- the evaluation of claims;
- the detection and prevention of fraud;
- the analysis of business results;
- purposes required or authorized by law.

For the purposes identified above, personal information may be disclosed to MedThree Insurance and any affiliated companies and service providers. Further information about Medthree Insurance personal information protection policy may be obtained by contacting their privacy officer at 416-477-2340.

WARRANTY STATEMENT

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. The undersigned also warrants that they have not suppressed or misstated any material facts. It is further agreed by the undersigned that each policy or renewal thereof, if issued, is issued in reliance upon the truth of the representations and information in this Application. If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned warrants he or she will immediately report such changes to the Insurer and the Insurer may modify or withdraw any quotation or agreement to bind or modify insurance.

Signing of this Application does not bind the undersigned to purchase this insurance, nor does it bind the Insurer to complete this insurance. However, should the Insurer bind and issue a policy, this Application shall serve as the basis of such contract and will be attached to and form part of the policy.

Any person who knowingly or with intent to defraud or to facilitate a fraud against any insurance company or other person submits an application or files a claim for insurance containing false, deceptive or misleading information may be guilty of insurance fraud.

IMPORTANT: THE APPLICANT MUST SIGN THIS APPLICATION. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

QUEBEC AND NEW BRUNSWICK RESIDENTS ONLY:

I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language.

SIGNATURE

Signature:		Date (mm/dd/yyyy):	
	(Authorized Representative)		
Name (please print):		Title/Position:	