A Healthcare and Life Sciences MGA

COMMITTED TO BROKERS

MED THREE INSURANCE GROUP

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?	☐ Yes	☐ 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?	☐ Existing Holder ☐ New Applicant				
5.	Describe your employment status:	☐ self-employed/independent contractor ☐ employed practitioner ☐ contract employee ☐ 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:	☐ sole proprietorship ☐ corporation ☐ professional corporation (Ontario only) ☐ partnership				
8.	Do you own or operate a healthcare entity?	☐ Yes ☐ 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	☐	Audiologist	☐	Podiatrist	☐
Chiropodist	☐	Chiropodist	☐	Psychologist	☐
Dental Hygienist	☐	Dental Hygienist	☐	Psychotherapist	☐
Dental Technologist	☐	Dental Technologist	☐	Registered Nurse	☐
Denturist	☐	Denturist	☐	Registered Practice Nurse	☐

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	Dietitian	☐	Dietitian	☐	Respiratory Therapist	☐
	Kinesiologist	☐	Kinesiologist	☐	Speech-language Pathologist	☐
	Medical Laboratory Technologist	☐	Medical Laboratory Technologist	☐		

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

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)	☐ Yes ☐ No			
Commercial General Liability (Occurrence)	☐ Yes ☐ 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

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6.	Are you aware of what to do in the event of fire or other emergency?	☐ Yes ☐ No ☐ N/A
7.	Do the premises have an emergency back-up system (e.g., for lighting, fire protection)	☐ Yes ☐ No ☐ N/A
8.	Are facilities for safe collection, storage and disposal of bio-medical waste provided in accordance with current guidelines/legislation?	☐ Yes ☐ No ☐ 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.?	☐ Yes ☐ No ☐ N/A
2.	Are there written procedures for you to handle medical emergencies (e.g., anaphylaxis)?	☐ Yes ☐ No ☐ N/A
3.	Are you certified in Basic Life Support?	☐ Yes ☐ No ☐ N/A
4.	Do you follow Health Canada and applicable provincial guidance for infection control including the reprocessing of reusable medical equipment and devices?	☐ Yes ☐ No ☐ N/A
5.	Are you trained on all equipment you use in your practice?	☐ Yes ☐ No ☐ N/A
6.	Does all equipment utilized in your practice undergo periodic inspection, testing, and preventive maintenance?	☐ Yes ☐ No ☐ N/A
7.	Are records of inspection, maintenance, testing and calibration of equipment kept?	☐ Yes ☐ No ☐ 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?	☐ Yes ☐ No ☐ N/A
9.	Are measures in place for the protection of patient/client health information in compliance with relevant privacy legislation?	☐ Yes ☐ No ☐ N/A
10.	Do you product or supply products?	☐ Yes ☐ No ☐ N/A
11.	Do you fit or alter products such as wheelchairs and like devices?	☐ Yes ☐ No ☐ N/A

SECTION 6 – CLAIMS AND INSURANCE HISTORY

A. Claims

1.	Have any negligence claims ever been made against you whether successful or otherwise?	☐ Yes ☐ No
2.	Have any claims for dishonesty ever been made against you whether successful or otherwise?	☐ Yes ☐ 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?	☐ Yes ☐ No
4.	Have you ever been convicted of violating any law, except a minor traffic offence, as a result of your profession?	☐ Yes ☐ No
5.	Have any sexual harassment and/or abuse claims ever been made against you?	☐ Yes ☐ 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":

Year of Incident	*Nature of Injuries*	*Injured Party*

B. Insurance History

1.	Have you ever been declined, cancelled or non-renewed by an insurance for Professional Liability Insurance?	☐ Yes ☐ No
2.	Have you ever been cancelled for non-payment?	☐ Yes ☐ No
3.	Has prior coverage been a Claims Made Basis?	☐ Yes ☐ No

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

Previous Insurer	*Policy No*	*Liability Limits*	*Premium*	*Expiry Date (mm/dd/yyyy)*

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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 evaluation of claims;
- the analysis of business results;
- the underwriting of policies;
- the detection and prevention of fraud;
- 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:	

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