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Professional and General Liability Insurance Application for: Fertility Clinic

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

All questions must be answered completely. Do not leave any space blank. Indicate "None" to questions where there is no exposure. If the space provided is insufficient to answer a question fully, please attach details on a separate sheet.

SECTION 1 – GENERAL INFORMATION

A. Full Legal Name of Applicant: (Please show complete name as you wish it to appear on the policy)	
Address:	
Website:	

B. Please list any subsidiary or related entities (e.g. Foundation, etc.) which are controlled by the entity and require coverage.

Name of Organization	Relationship to Applicant	Description of Operation	Country of Domicile

Note: Separate applications may be required for additional entities to be insured.

C. i. Number of years in operation:	
ii. Contact Details:	
iii. Administration Contact Name:	
Telephone:	E-Mail:
D. List academic, professional etc. institutions which the entity partners or is affiliated with, if applicable:	
E. Is the entity an accredited facility with Accreditation Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No Last year accredited:

SECTION 2 – FINANCIAL INFORMATION

A. i. Please provide the following information for the past, current and future financial years:			
	<i>Past Financial Year</i>	<i>Current Financial Year</i>	<i>Next Year (Estimate)</i>
Gross Revenue			
Operating Profit/Loss			
Net Cash			
ii. What percentages of patients treated are?	Canadian Residents: % Non-Canadian Residents: %		
iii. Annual number of patient visits for:			<i>Annual No. of Cycles</i>
	Assisted Hatching:		
	In vitro fertilization (IVF):		
	Intra-cytoplasmic Sperm Injection (ICSI):		
	Ovulation induction:		
	Superovulation:		

iv. Annual number of patient visits for:		<i>Annual No. of Cycles</i>
	Intrauterine Insemination (IUI):	
	Artificial insemination/Donor sperm insemination (DI):	
	Known Donor Egg Implantation:	
	Anonymous Donor Egg Implantation*:	
	Surrogacy:	
	Egg Cryopreservation (freezing):	
	Embryo Cryopreservation:	
	Sperm Cryopreservation:	
	Sperm Donation:	
	Testicular Sperm Extraction (TESE):	

*List sources (e.g., if US, specify state) of anonymous donor eggs:

SECTION 3 – PROFESSIONAL LIABILITY SECTION – THIS POLICY SECTION IS ON A CLAIMS MADE BASIS

Part 1 – Professional Services

A. Please provide the number of IVF cycles performed in the past, current and future financial years:

<i>Past Financial Year</i>	<i>Current Financial Year</i>	<i>Next Year (Estimate)</i>

B. Are any clinical trials undertaken? Yes No

If yes, please provide details:

C. Infection Prevention and Control:

i. Are standard precautions used when treating and caring for patients? Yes No

ii. Are clinic personnel educated in the use of accepted hand hygiene practices? Yes No

iii. Are single-use devices disposed of after use? Yes No

iv. Are reusable equipment and devices reprocessed in accordance with provincial guidance and manufacturers' recommendations? Yes No

v. Are sharps discarded into appropriate sharps' containers at point-of-use? Yes No

D. Informed Consent:

i. Is a patient's informed consent obtained for any medical procedure, test, intervention etc.? Yes No

ii. Is counselling offered to all women as part of the informed consent process? Yes No

iii. Is it documented in the informed consent process whether the offer of counselling it taken up or not? Yes No

E. Patient Records:

i. Is a patient record maintained for every patient receiving care? Yes No

ii. Are patient records treated as confidential with information only released to a third party with patient consent? Yes No

F. Does the entity have a documented strategy to minimize multiple births? Yes No

Part 2 – Procedures and Clinic Staff

A. Please indicate which of the following procedures/services the entity provides:

i. Alternative Therapies (e.g., Acupuncture) Yes No

ii. Artificial Insemination by Donor Yes No

iii. Artificial Insemination by Husband/Partner Yes No

iv. Assisted Hatching Yes No

v. Cervical Insemination Yes No

vi. Counselling Services Yes No

vii. Egg Collection/Harvesting Yes No

viii. Egg Donation Yes No

ix. Embryo Donation Yes No

x. Embryo Transfer Yes No

xi. Frozen Embryo Transfer	<input type="checkbox"/> Yes <input type="checkbox"/> No
xii. Genetic Screening	<input type="checkbox"/> Yes <input type="checkbox"/> No
xiii. Gestational Carrier	<input type="checkbox"/> Yes <input type="checkbox"/> No
xiv. Intrauterine Insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No
xv. In vitro Insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No
xvi. Intra-Cytoplasmic Sperm Injection	<input type="checkbox"/> Yes <input type="checkbox"/> No
xvii. Male Infertility Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
xviii. Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please provide details:

B. Cryopreservation Services:

i. Does the entity offer the following?	
Embryo Freezing and Storage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Semen Freezing and Storage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Egg Freezing and Storage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Are Embryo/Egg specimens stored in cryogenic storage tanks that are separate than those used for sperm specimens?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Are all storage tanks inspected daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. What is the minimum number of days the storage tanks can hold their temperature if unopened?	
v. Are all storage tanks continuously monitored by an electronic security system to assure proper storage conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
vi. Is there a secondary alert system in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
vii. Is the liquid nitrogen independent of any source of power?	<input type="checkbox"/> Yes <input type="checkbox"/> No
viii. Is there an uninterruptable power supply to support critical lab equipment including tank monitors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ix. Is the storage area locked at all times and access limited to authorized personnel only?	<input type="checkbox"/> Yes <input type="checkbox"/> No
x. Does the entity have a documented system in place that ensures the identification of all gametes and embryos from procurement to use or disposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Cord Blood Banking:

i. Are dedicated staff, facilities, and equipment provided for cord blood banking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Is the cord blood bank registered with Health Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Is the cord blood banking service AABB accredited?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Are banking facilities on site?	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Are Peristem™ (stem cells) services provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No

D. Laboratory Services:

i. Do laboratory personnel have the required expertise to undertake the assisted reproductive techniques offered by the clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Does the laboratory have detailed, documented quality management systems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Do all laboratory procedures include provision for unique patient identification, and corresponding gametes, zygotes and embryos identification, while retaining patient confidentiality?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Do written, signed and dated protocols exist for every procedure performed in the laboratory?	<input type="checkbox"/> Yes <input type="checkbox"/> No

E. Clinic Personnel:

i. Indicate total number of clinic personnel below:

	<i>Employees (on salary)</i>	<i>Independent Contractors</i>	<i>Part-time</i>	<i>Full-time</i>
Obstetricians/Gynecologists				
Embryologist				
Urologists				
Anesthesiologists				
Reproductive Endocrinology and Infertility Specialists				

Andrologists				
Sonographers				
Laboratory Technicians				
Pharmacists				
Pharmacy Technicians				
Registered Nurses (RNs)				
Nurse Practitioners				
Registered Practical Nurses (RPN/LPN)				
Psychologists				
Social Workers				
Clerical/Administration				
All other Employees				
Other Medical Specialties (please list below):				

- ii. Do all Independent Contractors carry Personal Professional Liability (Medical Malpractice) Insurance? Yes No
- iii. Are copies of certificates of insurance or evidence of insurance secured annually for each independent contractor? Yes No
- iv. Does the entity provide Professional Liability Coverage for any independent contractor? Yes No

- F. Adverse Events:
- i. Does the entity have a documented system in place for recording adverse events or "near misses"? Yes No
- ii. Does the entity undertake Root Cause Analysis of any adverse events or "near misses"? Yes No

- G. Third Party (TP) Contracts:
- i. Does the entity ensure that a documented TP contract is drawn up and signed? Yes No
- ii. Does the entity check that the TP provider has adequate liability insurance in place for the subject activities of the contract? Yes No

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

A. Brief description of premises:

<i>Building Location</i>	<i>Year Built</i>	<i>Size (sq.ft.)</i>	<i>Number of Storeys</i>

- B. Sub-contracted Services:
- i. Which of the following services does the entity sub-contract:
- | | |
|----------------------------------|--|
| Cleaning? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Security? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Waste Disposal? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Laundry? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Landscaping/lawn cutting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Parking Garage or Lot operation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other? Please describe: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- ii. Does the entity define the minimum limit of insurance that a sub-contractor must carry? Yes No
- iii. Does the entity insure that the name of the Applicant as an additional insured is added to sub-contractor's insurance? Yes No

- C. Are any fund-raising activities planned for the upcoming 12 months? Yes No
- If yes, please describe:

- D. Are employees enrolled in the provincial Workers' Compensation Board (or equivalent)? Yes No
- If no, please provide details of alternative Employee Benefit/Disability:

- E. How many employees drive their own personal vehicles on behalf of the organization (other than driving to and from work)?

- F. Do employees rent vehicles for short periods of time? Yes No

G. Do you own or operate a pay-for-parking lot or garage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. How many parking spaces do you operate?	
ii. What is the total revenue from these operations?	
iii. What security arrangements are in place for the parking lot or garage?	

SECTION 5 – PRIOR INSURANCE AND CLAIMS HISTORY

A. Please provide details of the entity's current insurance arrangements:

Coverage	Occurrence or Claims-Made Policy?	Retroactive Date (Claims-Made Policy)	Expiration Date	Current Limit	Current Deductible	Annual Premium
Professional Liability						
General Liability						
Management Liability						

B. Claims History:

i. Please attach a claims history from the entity's current insurer noting at least the following information:

Date of Loss/Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding (Reserve)	Description/ Nature of Allegations

ii. Are you aware of any facts, incident, circumstance or complaint that may reasonably give rise to a claim against the entity other than that noted in Question i. above? Yes No

If yes, please provide a listing of these in the format outlined below:

Date of Loss/Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding (Reserve)	Description/ Nature of Allegations

iii. a. Have all of the claims, facts, incidents, circumstances and/or complaints noted above in Questions i. and ii. been reported to your organization's previous or current insurers? Yes No

b. Have all of the claims, facts, incidents, circumstances and/or complaints noted above in Questions i. and ii. above been accepted by previous or current insurers and has your organization received verification in writing from the previous or current insurers? Yes No

iv. Have you ever had insurance Cancelled or Non Renewed for any reason? Yes No

If insurance has been declined or cancelled, please explain:

v. Name and Title of Individual designated to receive all notices from Insurers:

Name:
Title:

Without limitation of any other remedy available to the Insurer, it is hereby agreed that if there be knowledge of any such fact, circumstance or situation, any claim or action subsequently emanating therefrom is excluded from coverage under the proposed insurance.

SECTION 6 – COVERAGES – PLEASE INDICATE YOUR CURRENT INSURANCE REQUIREMENTS

Coverage	\$2,000,000	\$10,000,000	\$15,000,000	\$20,000,000	Deductible Amount
Professional Liability (Claims-Made Form)					
General Liability (Occurrence Form)					

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:	