A Healthcare and Life Sciences MGA

COMMITTED TO BROKERS

MEDTHREE INSURANCE GROUP

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Professional and General Liability Insurance Application for: Healthcare Establishments[1]

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 healthcare establishments – clinics, professional offices, medical centres etc.

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 of Applicant (Please print):					
	Name of Establishment to be insured:					
	Address:					
	City/Town:		Province:		Postal Code:	
	Phone No.:		E-Mail:			
	Website Address:			☐ N/A		
2.	Are you a current policy holder or a new applicant?	☐ Existing Holder ☐ New Applicant				
3.	What is the legal structure of the business?	☐ sole proprietorship ☐ partnership ☐ corporation ☐ other (describe):				
4.	Number of years the Establishment has been in operation:					
5.	Does a provincial College of Physicians and Surgeons (CPS) have oversight of the Establishment?	☐ Yes ☐ No ☐ N/A				
	If yes, what was the date of last CPS inspection (dd/mm/yyyy):					
	Were any conditions or restrictions placed on the operations of the Establishment by the CPS?	☐ Yes ☐ No				
	If yes, then give full details here:					
6.	List all accreditations and association memberships held by the Establishment (if none, write "None"):					
	Last year accreditation awarded:					

7. Please state sources and amounts of gross annual revenue in respect of the following years (in CAD):

	Last Complete Financial Year	*Estimate for Current Financial Year*	*Estimate for Next Financial Year*
Canadian Revenue			
USA Revenue			
Total revenue			

8.	What percentage of patients treated are:	Canadian Residents:	%	Non-Canadian Residents:	%	USA Residents: %
9.	How many visits/consultations/treatments/tests/procedures were performed during the past year?					
	If yes, please provide full details:					
10.	Please provide percentage of patients by age range:	< 30:	%	30-64:	%	> 65: %

SECTION 2 – ESTABLISHMENT INFORMATION

1. State the type of Establishment, all services that apply, and % of revenue and annual number of those services:

	Relative % of Revenue	*Annual No. of Services[2]*		*Relative % of Revenue*	*Annual No. of Services*
☐ **Diagnostic Centre:**					
X-Ray			Bone Density		
CT SCAN			Laboratory Services		
MRI			Hearing Testing		
Mammography			Prenatal Scanning		
Colonoscopy			Other (specify):		

[1] This application is not applicable to Fertility Clinics.

[2] Services include diagnostic tests, scans, surgeries, patient/client visits, counselling sessions etc.

	Relative % of Revenue	*Annual No. of Services*		*Relative % of Revenue*	*Annual No. of Services*
☐ **Surgical Centre:**					
Eye Surgery			General Surgery		
Orthopedic Surgery			Hair Transplant		
Cosmetic & Plastic Surgery			Other (specify):		
Podiatry Foot Surgery					
☐ **Medical Clinic:**					
General Family Medicine:			Foot Care/Podiatry Clinic		
Single Physician Office			Rehabilitation/Physiotherapy Clinic		
Group Practice			Dental Practice		
Family Health Team			Other (specify):		
Community Health Centre					
☐ **Service Provider Type:**					
Addiction Services			In-home Services		
Counselling Services			Other (specify):		
Pharmacy					

Please provide a complete description of products and services offered by the Applicant: (please attach promotional material)

2.	Does the Establishment maintain any beds for overnight occupancy (e.g., for post-operative recovery)?	☐ Yes ☐ No
i.	If yes, what is the total number of overnight beds?	
ii.	What is the average occupancy rate of your overnight beds?	
iii.	Is there a documented call rota for anesthesia service and the surgical specialty of any overnight admission?	☐ Yes ☐ No
3.	Does the Establishment provide telehealth or telemedicine services? **If no proceed to Section 3.**	☐ Yes ☐ No
i.	If yes, please give full details:	
ii.	Do you meet all the applicable licensing requirements in the jurisdiction involved in telehealth encounter?	☐ Yes ☐ No ☐ N/A
iii.	Do you meet all the credentialing requirements by healthcare facilities involved in telehealth encounter?	☐ Yes ☐ No ☐ N/A
iv.	Do you follow the standards set by the legislation or provincial / territorial regulatory bodies that apply to telehealth services?	☐ Yes ☐ No ☐ N/A
v.	Do you ensure that the technology used is of sufficient quality and reliability to make accurate healthcare assessments to patients?	☐ Yes ☐ No ☐ N/A

SECTION 3 – CLINICAL TRIALS

1.	Does the Establishment participate in Clinical Trials? **If no, proceed to Section 4.**	☐ Yes ☐ No
2.	Please state for whom Clinical Trials are undertaken (e.g., pharmaceutical company, Research Organization etc.):	
3.	Does the Establishment act as the site for clinical trials?	☐ Yes ☐ No
	If yes, are these clinical trials approved by the Establishment's Research Ethics Board?	☐ Yes ☐ No
4.	Do any clinical trials involve the following test subjects:	
	i. pregnant women?	☐ Yes ☐ No
	ii. children?	☐ Yes ☐ No
5.	Does the Establishment receive full indemnity from the Clinical Trial sponsors?	☐ Yes ☐ No
6.	Please provide annual revenue derived from clinical trial activity	
7.	How many trials were held during the last 12 months detailing the number of subjects in each trial:	
8.	What is the anticipated number of trials the Establishment will be involved in during the next 12 months detailing the number of subjects in each trial?	

SECTION 4 – 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*	*Limit $10 Million*
Professional Medical Malpractice (Claims Made)	☐ Yes ☐ No				
Commercial General Liability	☐ Yes ☐ No				

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

1.	Does the Establishment require Medical Director coverage for administrative duties only? Name of Medical Director:	☐ Yes ☐ No ☐ N/A
2.	Does the Establishment ensure that all its physicians (surgeons, anesthesiologists, dentists) are members of a Medical Defence Organization (CMPA) or otherwise carry personal professional liability insurance?	☐ Yes ☐ No ☐ N/A
	As part of the practitioner credentialing process, is evidence of this coverage required on an annual basis?	☐ Yes ☐ No

3. Staff Details:

State the number of employed and contracted staff (i.e., personnel that work at the Establishment that are NOT employees – self-employed):

Profession	*Employed* *Full-time*	*Part-time*	*Contracted*	*Profession*	*Employed* *Full-time*	*Part-time*	*Contracted*
Anesthiologists				Physicians			
Audiologists				Physician Assistants			
Care Aides / Personal Support Workers				Physiotherapists			
Chiropodists				Physiotherapy Assistants			
Chiropractors				Podiatrists			
Dental Assistants				Psychological Assistants			
Dental Hygienists				Psychologists			
Dental Technologists				Registered Nurses			
Dietician				Registered Practical Nurses			
ENT (Otholaryngologists)				Reg. Psychotherapists			
Gynaecologists				Social Workers			
Kinesiologists				Speech-Language Pathologists			
Medical Assistants				Urologist & Proctologists			
Medical Laboratory Technologist				Other (describe):			
Medical Radiation Technologist				Other (describe):			
Nurse Practitioners				Other (describe):			
Occupational Therapists				**Non-Health Personnel:**			
Opthalmologists,				Administrative			
Opticians				Clerical			
Optometrists				Other (describe):			
Orthopods & Cosmetic/ Plastic Surgeons				Other (describe):			
Paramedics				Other (describe):			
Pharmacists							

4.	Do all Independent Contractors carry their own Professional Liability (Medical Malpractice) insurance?	☐ Yes ☐ No
	If no, does the Establishment provide Professional Liability Coverage for these individuals?	☐ Yes ☐ No
5.	Are the professional licenses or certificates of all employees and independent contractors verified prior to their employment?	☐ Yes ☐ No
6.	Are there formal mechanisms for the selection, recruitment, orientation, and performance management of all personnel?	☐ Yes ☐ No
7.	Is informed consent obtained prior to all medical procedures/treatments/tests etc.?	☐ Yes ☐ No
8.	Do you have a documented risk management program?	☐ Yes ☐ No
9.	Do you have a formal program for clinical quality assurance?	☐ Yes ☐ No
10.	Is screening performed prior to diagnostic testing (e.g., subcutaneous metals before MRI) where applicable?	☐ Yes ☐ No ☐ N/A
11.	Is there a formal policy for the urgent transfer of patients to the nearest acute care hospital for the management of an urgent, adverse patient outcome (e.g., hemorrhage)?	☐ Yes ☐ No ☐ N/A
12.	Are professional personnel trained in emergency response during all hours of operation?	☐ Yes ☐ No ☐ N/A
13.	Do you follow the current guidance for infection prevention & control issued by the Public Health Agency of Canada; Ministry of Health or any regional; provincial / territorial public health authorities?	☐ Yes ☐ No ☐ N/A
	If yes, when was the guide last updated?	
	Do you have a written plan for managing an outbreak of a communicable disease in your facility?	☐ Yes ☐ No ☐ N/A

	Complete the following only if answers to the above questions are "No".	
	Is there a process of managing patient with symptoms of communicable disease to prevent transmission to others?	☐ Yes ☐ No ☐ N/A
	Do you follow the environmental cleaning protocol in the healthcare/ clinical environment?	☐ Yes ☐ No ☐ N/A
	Do you ensure the staff follow hand hygiene protocols?	☐ Yes ☐ No ☐ N/A
	Is immunization against flu required to all healthcare workers in your facility?	☐ Yes ☐ No ☐ N/A
	If no, please explain.	
	Are all equipment clean and disinfected / sterilized as per Routine Practices before reuse with another patient?	☐ Yes ☐ No ☐ N/A
	Are single use devices used and discarded in a waste receptacle after use?	☐ Yes ☐ No ☐ N/A
	Are the appropriate personal protective equipment (PPE) readily available and easily accessible to all staff?	☐ Yes ☐ No ☐ N/A
	Do you have protocols in placed to obtain and maintain adequate quantities of equipment, products, materials needed for the Infection prevention and control to prevent transmission of the disease?	☐ Yes ☐ No ☐ N/A
14.	Do staff receive training on all equipment they use in the Establishment prior to using it?	☐ Yes ☐ No ☐ N/A
15.	Has a formal laser safety program been established in accordance with all applicable standards, regulations, and professional standards?	☐ Yes ☐ No ☐ N/A
16.	Does the Establishment have a preventive maintenance program for all biomedical equipment?	☐ Yes ☐ No ☐ N/A
17.	Are there maintenance agreements for CT, MRI and other like equipment?	☐ Yes ☐ No ☐ N/A
	If yes, is there a maintenance agreement with a third party?	☐ Yes ☐ No
18.	Does the Establishment adhere to manufacturers' recommendations for the inspection and maintenance of equipment?	☐ Yes ☐ No ☐ N/A
19.	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
20.	Are measures in place for the protection of patient/client health information in compliance with relevant privacy legislation?	☐ Yes ☐ No

SECTION 6 – GENERAL LIABILITY

1.	Does the Establishment's landlord or municipality need to be shown as additional insured? If yes, please complete the Additional Insured Questionnaire.	☐ Yes ☐ No
2.	Is coverage required for any premises or buildings owned (wholly or in part) or operated by the Establishment?	☐ Yes ☐ No

If yes, please provide full details about the premises, including number of buildings, number of stories, date built, total square footage, number of stories, type of construction (e.g., concrete), and protection systems:

Location	*Year Built*	*Size (sq.ft.)*	*# of Storeys*	*Construction*	*Protection Systems*	
					Alarms	*Sprinklers*

3.	Are all contractors and sub-contractors required to provide proof of liability insurance and name the Establishment as an additional insured to their insurance?	☐ Yes ☐ No
4.	Are measures in place to ensure compliance with all regulatory workplace health and safety requirements?	☐ Yes ☐ No
5.	Are employees advised of and updated on their rights under Employment Standards legislation?	☐ Yes ☐ No
6.	Is there a written policy on the prevention of abuse (including sexual abuse) of clients/patients? If yes, please attach a copy of the policy.	☐ Yes ☐ No
7.	Is there written policy on the prevention and management of harassment/abuse of staff by clients/patients?	☐ Yes ☐ No
8.	Does the Establishment have formal, written protocols/procedures for handling allegations or complaints of abuse?	☐ Yes ☐ No
9.	Are all employees covered by the provincial Workers Compensation Board or equivalent?	☐ Yes ☐ No
	If no, is there an alternative Employee Benefit/Disability Program?	☐ Yes ☐ No
10.	What, if any, premises' function or facilities are sub-contracted (e.g., cleaning, waste disposal)? If none, put "None".	
11.	Do all premises comply with current fire precaution/prevention requirements?	☐ Yes ☐ No
12.	Are staff instructed and kept regularly informed of fire and emergency procedures?	☐ Yes ☐ No
13.	Are measures in place to ensure compliance with current regulations regarding the safe collection, storage, and disposal of all waste including sharps and other hazardous waste etc.?	☐ Yes ☐ No ☐ N/A
14.	Are facilities for safe collection, storage and disposal of bio-medical waste provided in accordance with current guidelines/legislation?	☐ Yes ☐ No
15.	Are secure facilities provided for the storage of controlled substances and narcotics?	☐ Yes ☐ No
16.	Do employees drive their personal vehicles for work-related purposes?	☐ Yes ☐ No
	If yes, do they report this to their personal automobile insurer?	☐ Yes ☐ No
	If yes, do they carry a minimum limit of $1 MM Automobile Third Party coverage on their personal automobile policy?	☐ Yes ☐ No

SECTION 7 – 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)*

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:	