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Main: 416-477-2353 FAX: 416-477-2399

Professional and General Liability Insurance Application for:
Healthcare Establishments¹

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:
2. Are you a current policy holder or a new applicant?
3. What is the legal structure of the business?
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?
6. List all accreditations and association memberships held by the Establishment (if none, write "None"):
7. Please state sources and amounts of gross annual revenue in respect of the following years (in CAD):
8. What percentage of patients treated are:
9. How many visits/consultations/treatments/tests/procedures were performed during the past year?
10. Please provide percentage of patients by age range:

SECTION 2 – ESTABLISHMENT INFORMATION

1. State the type of Establishment, all services that apply, and % of revenue and annual number of those services:
Table with columns: Relative % of Revenue, Annual No. of Services, and service types (Diagnostic Centre, X-Ray, CT SCAN, MRI, Mammography, Colonoscopy, Bone Density, Laboratory Services, Hearing Testing, Prenatal Scanning, Other (specify)).

¹ This application is not applicable to Fertility Clinics.

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

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

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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the Establishment provide telehealth or telemedicine services? If no proceed to Section 3.	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. If yes, please give full details:	
ii. Do you meet all the applicable licensing requirements in the jurisdiction involved in telehealth encounter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
iii. Do you meet all the credentialing requirements by healthcare facilities involved in telehealth encounter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
iv. Do you follow the standards set by the legislation or provincial / territorial regulatory bodies that apply to telehealth services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
v. Do you ensure that the technology used is of sufficient quality and reliability to make accurate healthcare assessments to patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

SECTION 3 – CLINICAL TRIALS

1. Does the Establishment participate in Clinical Trials? If no, proceed to Section 4.	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, are these clinical trials approved by the Establishment's Research Ethics Board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do any clinical trials involve the following test subjects:	
i. pregnant women?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the Establishment receive full indemnity from the Clinical Trial sponsors?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Commercial General Liability	<input type="checkbox"/> Yes <input type="checkbox"/> 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		Contracted	Profession	Employed		Contracted
	Full-time	Part-time			Full-time	Part-time	
Anesthesiologists				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 (Otolaryngologists)				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:			
Ophthalmologists,				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

Are you in compliance with all regulatory workplace health & safety requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complete the following only if answers to the above questions are "No".	
Is there a process of managing patient / customer with symptoms of communicable disease to prevent transmission to others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you follow the environmental cleaning protocol in the personal services environment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ensure that staff follows the hand hygiene protocols?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is immunization against flu required to all staff in your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain.	
Are all equipment clean and disinfected / sterilized as per current provincial best practices guidelines before reuse with another patient / customer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use single use towels or other protective covers on tables / beds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you dispose all waste including single use device in accordance with regulatory requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are all staff able to demonstrate adequate knowledge of general principles of infection control prevention including the common communicable disease risks for staff in the personal services setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are the appropriate personal protective equipment (PPE) readily available and easily accessible to all staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have protocols in place to obtain and maintain adequate quantities of equipment, products, materials needed for the Infection prevention and control to prevent transmission of the disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do staff receive training on all equipment they use in the Establishment prior to using it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
15. Has a formal laser safety program been established in accordance with all applicable standards, regulations, and professional standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
16. Does the Establishment have a preventive maintenance program for all biomedical equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
17. Are there maintenance agreements for CT, MRI and other like equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, is there a maintenance agreement with a third party?	
18. Does the Establishment adhere to manufacturers' recommendations for the inspection and maintenance of equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. 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

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
2. Is coverage required for any premises or buildings owned (wholly or in part) or operated by the Establishment? 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
<table border="1"> <thead> <tr> <th rowspan="2">Location</th> <th rowspan="2">Year Built</th> <th rowspan="2">Size (sq.ft.)</th> <th rowspan="2"># of Storeys</th> <th rowspan="2">Construction</th> <th colspan="2">Protection Systems</th> </tr> <tr> <th>Alarms</th> <th>Sprinklers</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Location	Year Built	Size (sq.ft.)	# of Storeys	Construction	Protection Systems		Alarms	Sprinklers															
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
4. Are measures in place to ensure compliance with all regulatory workplace health and safety requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
5. Are employees advised of and updated on their rights under Employment Standards legislation?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
7. Is there written policy on the prevention and management of harassment/abuse of staff by clients/patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
8. Does the Establishment have formal, written protocols/procedures for handling allegations or complaints of abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
9. Are all employees covered by the provincial Workers Compensation Board or equivalent? If no, is there an alternative Employee Benefit/Disability Program?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No																							
12. Are staff instructed and kept regularly informed of fire and emergency procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																							

14. 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
15. Are secure facilities provided for the storage of controlled substances and narcotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Do employees drive their personal vehicles for work-related purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do they report this to their personal automobile insurer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do they carry a minimum limit of \$1 MM Automobile Third Party coverage on their personal automobile policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 7 – 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":										
<table border="1"> <thead> <tr> <th><i>Year of Incident</i></th> <th><i>Nature of Injuries</i></th> <th><i>Injured Party</i></th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	<i>Year of Incident</i>	<i>Nature of Injuries</i>	<i>Injured Party</i>							
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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 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:	