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Professional and General Liability Insurance Application for: Medical Transport Organization

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

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):					
	Address:					
	City/Town:		Province:		Postal Code:	
	Phone No.:		E-Mail:			
	Website Address:				☐ N/A	
2.	What is the legal structure of the business?		☐ sole proprietorship ☐ partnership ☐ corporation ☐ other (describe):			
3.	Number of years the Establishment has been in operation:					
4.	List all accreditations and association memberships held by the Establishment (if none, write "None"):					
	Date of latest accreditation:					
5.	Have all relevant federal, provincial and municipal certifications for legislated standards, regulatory compliance and quality assurance been complied with?				☐ Yes ☐ No	
6.	Please state 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*

SECTION 2 – SERVICES

Please provide a complete description of the applicant's activities:

Indicate all types of services that apply:

	No. of Flights	*No. of Trips*		*No. of Flights*	*No. of Trips*
Medical Escorts:			Ground Ambulance – Non-Urgent Care:		
Repatriation: Air Ambulance – Basic (Domestic):			Ground Ambulance – Urgent: Ground Ambulance – Neonatal/Pediatric:		
Air Ambulance – Basic (International):			Medevac (Domestic):		
USA:			Medevac (International):		
Rest of the World:			Organ Transport – Air:		
Air Ambulance – Critical (International):			Organ Transport – Ground:		
USA:			Other – Please provide complete description:		
Rest of the World:					
Air Ambulance – Neonatal/ Pediatric:					
CANADA:					
USA:					
Rest of the World:					

Please provide percentage of patients by age range:

< 30 30-64 > 65

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SECTION 3 – INSURANCE COVERAGE REQUIRED

Please indicate 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				
Commercial General Liability				

SECTION 4 – STAFFING

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*	
Paramedic				Registered Nurse			
Physician				Emergency Medical Technician			
Respiratory Therapist				Administration / Clerical			
Neonatal Critical Care Nurse				Other (describe):			
Critical Care Nurse				Other (describe):			

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

1. Does the Establishment require Medical Director coverage for administrative duties only?	☐ Yes ☐ No ☐ N/A
Name of Medical Director:	
2. Does the Establishment ensure that all its physicians are members of a Medical Defence Organization (CMPA) or otherwise carry personal professional liability insurance and that the indemnity or coverage provided is applicable to the services being provided for the Insured?	☐ Yes ☐ No ☐ N/A
3. How many medical personnel attend to each flight and / or patient transfer?	
4. Do you provide “bedside to bedside service”?	☐ Yes ☐ No ☐ N/A
5. How often do you conduct patient handling training?	
6. Describe the Medical Director’s duties or involvement in the daily operations:	
7. Are there policies and procedures for the communication during patient hand-overs?	☐ Yes ☐ No ☐ N/A

SECTION 6 – GENERAL LIABILITY

1. 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:

Location Address	*Size (sq. ft.)*

2. Do you own any aircraft or ambulances?	☐ Yes ☐ No
If yes, please provide details on a separate sheet.	
If yes, do you have an aviation and / or an automobile liability insurance in placed?	☐ Yes ☐ No

SECTION 7 – RISK MANAGEMENT

Abuse Protocols	
1. Is there a written policy on the prevention of abuse (including sexual abuse) of clients/patients?	☐ Yes ☐ No
If yes, please attach a copy of the policy.	
2. Is there written policy on the prevention and management of harassment/abuse of staff by Clients/patients?	☐ Yes ☐ No
3. Does the Establishment have formal, written protocols/procedures for handling allegations or complaints of abuse?	☐ Yes ☐ No
Employment	
1. 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
2. Are there formal mechanisms for the selection, recruitment, orientation, and performance management of all personnel?	☐ Yes ☐ No
Quality Assurance	
1. Do you have a documented risk management program?	☐ Yes ☐ No
2. Do you have a formal program for clinical quality assurance?	☐ Yes ☐ No
Service Agreement	
1. Do you have a service agreement in place and to contractually hold you harmless?	☐ Yes ☐ No
2. Are there maintenance agreements for medical equipment?	☐ Yes ☐ No
If yes, is there a maintenance agreement with a third party?	☐ Yes ☐ No

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3.	Are all contractors required to provide proof of liability insurance and name the Establishment as additional insured too their insurance and do you retain copies of insurance certificates?	☐ Yes ☐ No

Privacy

Are measures in place for the protection of patient/client health information in compliance with relevant privacy legislation?	☐ Yes ☐ No

Infection Prevention and Control

1.	Are you in compliance with all regulatory workplace health & safety requirements?	☐ Yes ☐ No
2.	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
	If yes, when was the guide last updated?	
3.	Do you have a written plan for managing an outbreak of a communicable disease in your facility?	☐ Yes ☐ No

Complete the following only if answers to the above questions are "No".

4.	Is there a process of managing patient / customer with symptoms of communicable disease to prevent transmission to others?	☐ Yes ☐ No
5.	Do you follow the environmental cleaning protocol in the personal services environment?	☐ Yes ☐ No
6.	Do you ensure that staff follows the hand hygiene protocols?	☐ Yes ☐ No
7.	Is immunization against flu required to all staff in your facility?	☐ Yes ☐ No
	If no, please explain.	
8.	Are all equipment clean and disinfected / sterilized as per current provincial best practices guidelines before reuse with another patient / customer?	☐ Yes ☐ No
9.	Do you use single use towels or other protective covers on tables / beds?	☐ Yes ☐ No
10.	Do you dispose all waste including single use device in accordance with regulatory requirements?	☐ Yes ☐ No
11.	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?	☐ Yes ☐ No
12.	Are the appropriate personal protective equipment (PPE) readily available and easily accessible to all staff?	☐ Yes ☐ No
13.	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

SECTION 8 – CLAIMS AND INSURANCE HISTORY

A. Claims

1.	Have any claims ever been made against you whether successful or otherwise?	☐ Yes ☐ No
2.	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

3. Please list all claims and incidents that may result in a claim, prior to the effective date of this proposed policy, 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.	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.

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

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