A Healthcare and Life Sciences MGA

COMMITTED TO BROKERS

MEDTHREE INSURANCE GROUP

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MAIN: 416-477-2353 FAX: 416-477-2399

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?	☐ Yes ☐ No	Last year accredited:	

SECTION 2 – FINANCIAL INFORMATION

A. i. Please provide the following information for the past, current and future financial years:

	Past Financial Year	*Current Financial Year*	*Next Year (Estimate)*
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:

		Annual No. of Cycles
Assisted Hatching:		
In vitro fertilization (IVF):		
Intra-cytoplasmic Sperm Injection (ICSI):		
Ovulation induction:		
Superovulation:		

iv. Annual number of patient visits for:			*Annual No. of Cycles*
	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:

Past Financial Year	*Current Financial Year*	*Next Year (Estimate)*

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	☐ Yes ☐ No
xii.	Genetic Screening	☐ Yes ☐ No
xiii.	Gestational Carrier	☐ Yes ☐ No
xiv.	Intrauterine Insemination	☐ Yes ☐ No
xv.	In vitro Insemination	☐ Yes ☐ No
xvi.	Intra-Cytoplasmic Sperm Injection	☐ Yes ☐ No
xvii.	Male Infertility Treatment	☐ Yes ☐ No
xviii.	Other:	☐ Yes ☐ No

If yes, please provide details:

B. Cyropreservation Services:

i. Does the entity offer the following?

Embryo Freezing and Storage?	☐ Yes ☐ No
Semen Freezing and Storage?	☐ Yes ☐ No
Egg Freezing and Storage?	☐ Yes ☐ No

ii.	Are Embryo/Egg specimens stored in cryogenic storage tanks that are separate than those used for sperm specimens?	☐ Yes ☐ No
iii.	Are all storage tanks inspected daily?	☐ Yes ☐ 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?	☐ Yes ☐ No
vi.	Is there a secondary alert system in place?	☐ Yes ☐ No
vii.	Is the liquid nitrogen independent of any source of power?	☐ Yes ☐ No
viii.	Is there an uninterruptable power supply to support critical lab equipment including tank monitors?	☐ Yes ☐ No
ix.	Is the storage area locked at all times and access limited to authorized personnel only?	☐ Yes ☐ 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?	☐ Yes ☐ No

C. Cord Blood Banking:

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

D. Laboratory Services:

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

E. Clinic Personnel:

i. Indicate total number of clinic personnel below:

	Employees (on salary)	*Independent Contractors*	*Part-time*	*Full-time*
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 <u>OCCURRENCE BASIS</u>

A. Brief description of premises:

Building Location	*Year Built*	*Size (sq.ft.)*	*Number of Storeys*

B. Sub-contracted Services:

i. Which of the following services does the entity sub-contract:

Cleaning? ☐ Yes ☐ No

Security? ☐ Yes ☐ No

Waste Disposal? ☐ Yes ☐ No

Laundry? ☐ Yes ☐ No

Landscaping/lawn cutting? ☐ Yes ☐ No

Parking Garage or Lot operation? ☐ Yes ☐ No

Other? Please describe: ☐ Yes ☐ 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?	☐ Yes ☐ 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 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:	