COMPLEMENTARY MEDICAL PRACTITIONERS APPLICATION

PLEASE ANSWER ALL QUESTIONS
IF THEY DO NOT APPLY, INDICATE "N/A" - IF SPACE IS INSUFFICIENT PLEASE USE SEPARATE SHEETS

1. Name of Insured: _____

   Date of Birth: _____

2. Trading Name (if different from above): _____

3. Have you ever engaged in a similar activity under a different name? ☐ Yes ☐ No
   If Yes, please give full details:

   _____

   _____

4. i) Address: _____

   ii) Practice/Trading Address
   (if different from above): _____

   If cover is required for more than one location, please attach a list of all addresses.

5. i) What is your total gross annual income excluding income from the sale of goods?
   If new business please state estimated income for the forthcoming 12 months:

   _____

   ii) What percentage of your total gross annual income will be earned:

   ☐ In the U.S.A. _____ % ☐ Other foreign _____ %

   iii) Total number of:

   Treatments _____ Sessions _____ Consultations _____

6. i) In what branch or branches of complementary medicine are you qualified and, if applicable, licensed to practice?

☐ Acupuncture	☐ Acupressure	☐ Alexander Technique
☐ Aromatherapy	☐ Ayurveda	☐ Bach Remedies
☐ Bates Method	☐ Biochemics	☐ Chiropractic
☐ Colonic Irrigation	☐ Colour Therapy	☐ Craniosacral Therapy
☐ Crystal Therapy	☐ Counselling	☐ Healing / Reiki
☐ Herbalism	☐ Homeopathy	☐ Hypnosis
☐ Iridology	☐ Kinesiology	☐ Light Touch Therapy
☐ Massage	☐ Moxibustion	☐ Music Therapy
☐ Multi Vitamin Therapy	☐ Naturopathy	☐ Nutrition Therapy
☐ Osteopathy	☐ Polarity Therapy	☐ Psychotherapy
☐ Radionics	☐ Reflexology	☐ Rolfing
☐ Shiatsu	☐ Yoga	

☐ Other (Please specify): _____

ii) Please provide on a separate piece of paper, full details of all qualifications and courses that you have undertaken, on the above branches of Medicine.

7. Please give full details of what patient records are kept, where and how they are stored and for how long they are retained:

_____

Please note it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

8. Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed:

	Employed	Self-Employed
The applicants private practice	_____	_____
Clinics	_____	_____
Private Non-surgical Nursing	_____	_____
Homes and Hospices	_____	_____
Patients' Homes	_____	_____
Other (please specify)	_____	_____
TOTAL	_____	_____

If you are an employee, please state the name of the company (or other entity) for whom you work:

_____

9. Do you own (wholly or in part), operate or administer any hospital, nursing home or any other medical establishment? ☐ Yes ☐ No
If Yes ,an additional application form will have to be completed before quotations can be given.

10. i) Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e. Hepatitis, H.I.V. etc or other impediment which may affect the performance of his/her professional duties or place patients/clients at risk? ☐ Yes ☐ No
If Yes, what procedures are in place?

_____

_____

ii) Has the applicant or any employee involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries? ☐ Yes ☐ No
If Yes, please give full details:

_____

_____

11. Are you a member of any professional organization, or registered with any self regulating body? ☐ Yes ☐ No
If Yes, please state which and period of membership / registration:

_____

12. If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance? ☐ Yes ☐ No
If Yes, please give full details:

_____

13. Are you currently Insured for Medical Professional Liability? ☐ Yes ☐ No

i) If Yes, please indicate the name of the Insurer:

_____

ii) Please indicate if such coverage is offered on an occurrence basis or claims made basis.

☐ Occurrence ☐ Claims Made

iii) If current coverage is on a claims made basis, what is the retroactive date? _____

iv) What is your current policy limit? _____

v) What is your current deductible? _____

vi) If you are presently insured, are renewal terms being offered? ☐ Yes ☐ No
If No, please state reason:

_____

14. Please complete for members of staff to be covered:

Full Time/Part Time	Branch of Medicine	Qualifications	Date Qualifed

15. To your knowledge, has any company declined or terminated the insurance for you, any present partner or officer or for any predecessor in the business, past partners or officers? ☐ Yes ☐ No
If Yes, please provide details:

_____

_____

16. a) Have any claims ever been made to your knowledge against you, any business predecessors, or any of the present or former partners or officers? ☐ Yes ☐ No

b) Are you aware of any act, error, omission or circumstances which could give rise to a claim against you or any predecessor in business, or any present or former partner or officer? ☐ Yes ☐ No

IF THE ANSWER TO EITHER Q.16 a) OR Q.16 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 16. a) AND/OR 16. b) OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

17. Insurance required:

LIMITS:		**DEDUCTIBLES:**	
	$1,000,000 ☐		$ 1,000 ☐
	$2,000,000 ☐		$ 2,500 ☐
	$3,000,000 ☐		$5,000 ☐
	$4,000,000 ☐		$10,000 ☐
	$5,000,000 ☐		$25,000 ☐
	$6,000,000 ☐		Other _____
	$7,000,000 ☐		
	$8,000,000 ☐		
	$9,000,000 ☐		
	$10,000,000 ☐		
	Other _____		

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed or misstated any material facts and I/we agree that this declaration shall be the basis of any binder or contract or insurance with the Insurer, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurer to the issue of the insurance nor the Applicant to the purchase of the insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 16. a) or 16. b) of this application, the Insurer shall be immediately notified in writing of such information.

THE UNDERSIGNED HEREBY ACKNOWLEDGES THE TRUTH OF THE STATEMENTS CONTAINED HEREIN.

I AUTHORIZE YOU TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION AS PERMITTED BY LAW, IN CONNECTION WITH YOUR COMMERCIAL INSURANCE POLICY OR A RENEWAL, EXTENSION OR VARIATION THEREOF, FOR THE PURPOSES NECESSARY TO ASSESS THE RISK, INVESTIGATE AND SETTLE CLAIMS, AND DETECT AND PREVENT FRAUD, SUCH AS CREDIT INFORMATION, AND CLAIMS HISTORY.

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

Signature of Applicant (authorized representative) Date

SUBMITTED BY: _____

EMAIL: _____

For contact information visit:
www.markelinternational.ca

CLAIMS HISTORY

Applicants Name: ______________________________ Date: ______________

Claimant: ______________________________

Date of Loss: ______________________________ Suit: ☐ Yes ☐ No

Amount Claimed: ______________________ Estimated Liability: ______________

Indemnity Paid: ______________________ Expenses Paid: ______________

Closed: Yes ☐ No ☐

Description of Claim: ______________________________

Applicants Name: ______________________________ Date: ______________

Claimant: ______________________________

Date of Loss: ______________________________ Suit: ☐ Yes ☐ No

Amount Claimed: ______________________ Estimated Liability: ______________

Indemnity Paid: ______________________ Expenses Paid: ______________

Closed: Yes ☐ No ☐

Description of Claim: ______________________________

Applicants Name: ______________________________ Date: ______________

Claimant: ______________________________

Date of Loss: ______________________________ Suit: ☐ Yes ☐ No

Amount Claimed: ______________________ Estimated Liability: ______________

Indemnity Paid: ______________________ Expenses Paid: ______________

Closed: Yes ☐ No ☐

Description of Claim: ______________________________
