CORPORATE HEALTH PROVIDERS
MEDICAL PROFESSIONAL LIABILITY APPLICATION

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

1. i) Name of Insured: _____

   ii) Trading Name (if different from above): _____

   iii) How long has the establishment been trading under the above name? _____

2. Has the Insured or its principals engaged in any Healthcare activities under a different title in the last five years? If so, please provide details on a separate sheet identifying: Title, Trading and Registered Address, Nature of Services.

3. i) Trading Address: _____

   ii) Registered office (if different from above): _____

   If cover is required for additional locations, a separate application for each must be completed.

4. i) Please name the ultimate Owner or Holding Company:

   _____

   ii) Please identify any corporate or private entity of foreign origin that has any ownership or interest in either the Insured or the Insured's ultimate owner or holding company and their percentage holding:

   _____

   iii) Length of current operation by present Parent/Owner: _____

5. i) Please state your total Gross Fee Income / Sales / Gross Receipts / Government Funding:
   a) for the past Financial Year _____
   b) estimate for the Current Financial Year _____

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

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

iii) Please state the approximate number of patients/clients:

a) During the last Financial Year _____

b) During your Current Financial Year _____

6. i) PLEASE GIVE A FULL DESCRIPTION OF YOUR BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (this must be answered):

_____

_____

_____

ii) Please check if you are involved in any of the following and, where indicated*, complete the relevant Addendum:

		% total income
Assisted Conception Unit *	☐	_____
Autologous Bloodbank	☐	_____
Clinical Research Establishment *	☐	_____
Health & Fitness Centre / Gym *	☐	_____
Industrial / Occupational Health & Safety *	☐	_____
Health Screening Centre / Mobile Unit *	☐	_____
Inoculation / Travel Centre	☐	_____
Medical Personnel / Employment Agency *	☐	_____
Medical Teaching Facility	☐	_____
Nursing Teaching Facility	☐	_____
Pathology Laboratory *	☐	_____
Repatriation &/or Ambulance Service *	☐	_____

iii) What, if any, substantial changes in your activities or major new developments are likely to occur within the next 12 months?
Please give full details:

_____

_____

7. i) Are you licensed or registered in accordance with the applicable regulatory body or law to practice those procedures at the address specified in Question 3 for which indemnification is required? ☐ Yes ☐ No
If No, please give a full explanation why not:

_____

_____

ii) Please identify your memberships or registration with Association or Professional Bodies or Licensing Authorities:

_____

_____

iii) Has membership or registration with such, ever been suspended, withdrawn, amended, declined or had conditions attached? ☐ Yes ☐ No
If Yes, please give full details:

_____

_____

PLEASE <u>NOTE</u> THAT THIS POLICY IS DESIGNED TO COVER CLAIMS MADE AGAINST THE INSURED DURING THE POLICY PERIOD. IF COVER IS ALSO REQUIRED FOR CLAIMS MADE AGAINST REGISTERED MEDICAL / DENTAL PRACTITIONERS FOR WORK PERFORMED FOR THE INSURED, PLEASE SUPPLY A LIST OF ALL SUCH PRACTITIONERS FOR WHOM COVERAGE IS REQUIRED STATING THE NAME, DATE OF BIRTH, QUALIFICATIONS AND PRACTICE OF EACH PRACTITIONER. IN ADDITION TO THIS PLEASE CONFIRM WHETHER OR NOT THE PRACTITIONERS ARE EMPLOYED BY THE INSURED OR SELF-EMPLOYED.

8. Do you ensure and record that at all times all Registered Medical and Dental Practitioners are members or a Medical / Dental Defence Organization, recognized by your National Medical / Dental Association, or are otherwise fully insured for their own malpractice? ☐ Yes ☐ No
If the answer is No, please refer to the Note above.

9. Please state the total number of persons involved in the following capacities:

	Employed by the Insured	Self-Employed
Non-procedural Physicians:		
Psychiatrists	_____	_____
Other	_____	_____

	Employed by the Insured	Self-Employed
Surgeons:		
Cosmetic		
Orthopedic		
Other		
Anesthetists		
Obstetricians		
Gynecologists		
Lab / Path technicians		
Dentists		
Midwives		
Nurses - Day		
Nurses - Night		
Pharmacists		
Paramedics		
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries - Day		
Auxiliaries - Night		
Counsellors		
Directors / Partners / Principals		
Clerical / Administration		
Other (please specify)		

10. Are any counselling services made available to patients? ☐ Yes ☐ No
If Yes,

i) Please indicate in which of the following categories:

	Number of Counsellors	Employed	Self-Employed	Number of Patients
Assisted Conception				
Drug / Alcohol Dependency				
Elective Cosmetic				
Gender Reassignment				

	Number of Counsellors	Employed	Self-Employed	Number of Patients
HIV / HEP / STD				
Sterilization				

Other (please specify): _____

ii) Do all counselors hold appropriate qualifications? ☐ Yes ☐ No
Please provide details:

_____

_____

11. 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?

_____

_____

12. i) Please state: Total number of Day Care Beds: _____
Total number of Overnight Beds: _____

ii) Please state what, if any, percentage of patients / clients in the last year came from USA: _____ %

iii) Please state what, if any, percentage of patients / clients in the last year who may be resident in Canada, come from USA: _____ %

13. i) Do you provide facilities for the sterilization of instruments in accordance with current guidelines? ☐ Yes ☐ No
If No, please provide details of what arrangements are in place for this:

_____

_____

If Yes, do you ensure that effective cross-infection control methods are employed?

_____

_____

ii) Do you have a protocol for needlestick injuries? ☐ Yes ☐ No
If No, please give full details:

14. Please give full details of what 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.

If you require Public Liability Insurance please complete the following section:

Premises Coverage

15. Please give full details about the premises, including number of buildings and their age and any anticipated material developments:

i) Number of buildings: _____

ii) Please give brief details of legislation that applies to the testing and servicing of water tanks, air conditioning units, etc.:

iii) Are elevators, hoists, escalators and the like regularly serviced under contract? ☐ Yes ☐ No

iv) a. What premises functions or facilities do you sub-contract?

b. What systems are in place to ensure that those sub-contractors carry adequate insurance and name your organization as an additional named Insured to their insurance?

16. i) Do the Premises comply with current fire precaution / prevention requirements? ☐ Yes ☐ No
If No, please give full details:

_____

_____

ii) Are staff instructed and kept regularly appraised in fire and emergency procedures? ☐ Yes ☐ No

iii) Do the premises have an emergency electrical system? ☐ Yes ☐ No

17. i) Do you provide facilities for safe collection, storage and disposal in accordance with current guidelines / legislation of:

a. "Sharps"? ☐ Yes ☐ No

b. Dressings, clinical / surgical waste, etc? ☐ Yes ☐ No

ii) Do you ensure that the following are safely disposed of in accordance with current guidelines / legislation:

a. all blood / blood products? ☐ Yes ☐ No

b. all other waste? ☐ Yes ☐ No

Previous Insurance History
(Please refer to your Broker if you are in doubt as to what is being asked of you in this Section)

<u>For Each Policy</u>

18. 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:

_____

19. Has any application for these types of insurance cover ever been: ☐ Yes ☐ No

i) declined ☐ Yes ☐ No

ii) cancelled ☐ Yes ☐ No

iii) required special terms ☐ Yes ☐ No

If "Yes" please provide full details on a separate page.

20. 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:

_____

_____

21. 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.21 a) OR Q.21 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 21. a) AND/OR 21. 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.

22. Insurance required:

LIMITS:	$1,000,000	☐	**DEDUCTIBLES:**	$ 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	_____

LIMITS:

$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 21. a) or 21. 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

ADDENDUM 1 – ASSISTED CONCEPTION

1. If an Assisted Conception Unit is maintained, please give a full percentage breakdown of all procedures undertake:

   A.I.H. _____ %

   A.I.D. _____ %

   I.V.F. / E.T. / P.R.O.S.T. _____ %

   Frozen Embryo Replacement _____

   Other (please specify and indicate percentage): _____ _____ %

2. Is all donor semen screened, cryopreserved and quarantined in line with current recommendations? ☐ Yes ☐ No

ADDENDUM 2 – CLINICAL RESEARCH

1. Please state for whom Clinical Research Projects are undertaken e.g. Pharmaceutical and other Manufacturers, Charities, Research Foundations:

   _____

2. Do you receive a full indemnity from your Principals? ☐ Yes ☐ No
3. Do all volunteers sign an Informed Consent Form? ☐ Yes ☐ No
4. If Double Blind studies are undertaken are volunteers made fully aware of this? ☐ Yes ☐ No
5. Does any trial involve any female volunteers of child-bearing years? ☐ Yes ☐ No
   If Yes, please provide full details:

   _____

   _____

6. Please state the Annual Income or Sales: _____

7. Please state the number of trials during the last 12 months detailing the number of volunteers in each trial:

8. Please state the anticipated number of trials with which you will be involved during the next 12 months detailing the number of volunteers in each trial:

9. Do you conduct any formal research, testing or experimental activities in the following categories:

Transplant	Human Embryo Research	
Surgery	Artificial Organ	
Obstetrics	Genetic Engineering	☐ Yes ☐ No

If Yes, please attach full details.

Please provide a copy of your Volunteer Informed Consent and any indemnity referred to in question 2 above.

ADDENDUM 3 – HEALTH & FITNESS CENTRES

1. Please state the approximate percentage of your income within the following categories:

Gym / Exercise		%
Diet / Nutrition		%
Sunbeds /Solarium		%
Hairdressing		%
Beauty Therapy		%
Electrolysis		%
Ear Piercing		%
Other (please specify):		

2. Please state the number and type of Complimentary Therapists:

_____

PLEASE ENCLOSE A COPY OF ANY OR ALL QUESTIONNAIRES THAT CLIENTS MUST COMPLETE PRIOR TO TREATMENT. IF THERE IS NONE STATE "NONE".

ADDENDUM 4 – INDUSTRIAL / OCCUPATIONAL HEALTH

1. Is your work solely "in-house" i.e. limited to other divisions or companies with common ownership to yourselves? ☐ Yes ☐ No
   If No, please give full details:

_____

2. Please give full details of any outpatient or other medical facilities made available to staff:

_____

3. Is health screening made available? ☐ Yes ☐ No
   IF YES, PLEASE COMPLETE THE FOLLOWING ADDENDUM:

ADDENDUM 5 – HEALTH SCREENING

1. Please give an approximate percentage breakdown of your patients between the following categories:

   Insurance Medicals _____ %

   General Fitness Assessment _____ %

   Well Woman / Well Man _____ %

   A.I.D.S. Testing _____ %

   Other (please specify): _____

2. Do you have C.A.T. / M.R.I. scanners or similar? ☐ Yes ☐ No
   If Yes, please give details including date of purchase, details of any service contract or guarantee:

_____

ADDENDUM 6 – MEDICAL PERSONNEL AGENCIES

1. What are the minimum acceptable qualifications and years of experience in respect of the following:

   i) Nurses _____

   ii) Midwives _____

   iii) Other (please specify) _____

2. Are all staff vetted and references taken up? ☐ Yes ☐ No
   If No, please give full details:

_____

3. Do you ensure that all nurses and midwives supplied by you maintain membership of their respective associations or are otherwise insured for Medical Professional Liability? ☐ Yes ☐ No

ADDENDUM 7 – PATHOLOGY LABORATORIES

1. Do you administer any pathology laboratories in medical establishments outside your ownership? ☐ Yes ☐ No
   If Yes, please give full details:

_____

2. What procedures are in place to ensure that results are promptly received by whom they were requested?

_____

_____

3. Please give an approximate percentage breakdown by income between the following:

   i) Human Pathology _____ %

   ii) Animal Pathology _____ %

iii) Drug Testing _____ %

iv) Other e.g. Legionnaires / Salmonella, etc. (please specify and give full details):

_____

Within (i) above please confirm what percentage, if any, of your income / sales / gross receipts is derived from A.I.D.S. testing.

If none state NONE: _____ %

ADDENDUM 8 – REPATRIATION / AMBULANCE SERVICES

1. Please state the

   i) Number of Ambulances in operation: _____

   ii) Number of crew members per Ambulance: _____

   iii) Minimum acceptable qualifications of crew members: _____

   iv) Average number of routine trips to hospitals, nursing homes, etc. per year: _____

   v) Average number of emergency calls per year: _____

2. Is an Air Ambulance repatriation service maintained? ☐ Yes ☐ No
   If Yes please state:

   i) In which countries you anticipate operating: _____

   ii) The number of repatriations per year: _____

3. Do you provide private Ambulance or First Aid at public events? ☐ Yes ☐ No
   If Yes please give details of:

   i) The type and size of event for which services are provided:

   _____

   ii) The number of events per year: _____

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: ______________________
