LATITUDE ADVANTAGE MD
APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

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

The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

Non-Resident Patient means, a natural person, ordinarily resident outside of Canada, who retains the Insured for medical treatment while a visitor in Canada whether for personal or business reasons.

GENERAL INFORMATION

1. Full Name of Applicant: ______________________

   Clinic Name: ______________________

   Address:

   If other locations apply, please comment in Appendix D

2. Website (if applicable): ______________________

3. Date of Birth: ____________ Place of Birth: ______________________

4. Are you a Canadian Citizen? ☐ Yes ☐ No
   If No, what is your status in Canada and Current citizenship:

   ____

5. What is the status of your business:

   ☐ Solo Practitioner (unincorporated) ☐ Solo Practitioner (incorporated) ☐ Professional Corporation
   ☐ Professional Association ☐ Limited Liability Company ☐ Partnership
   ☐ Employee of ☐ Independent Contractor of ☐ Other

6. Do you want coverage for the Entity named above? ☐ Yes ☐ No

   Please attach a copy of your letterhead to this application.

7. Provide the following information for all of the Provinces in which you practice:

Province	License No.	Effective Date	Expiration Date	Active Yes - No

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

Name	City	Prov.	% of Work	Type of Privileges

9. Are you currently a hospital Chief of Staff or head of any hospital Department? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

10. Do you or the clinic named in Item 2 above, own (either wholly or in part), operate or administer any hospital, nursing home, surgi-center, urgent care center or other facility where medical services are provided? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

Education and Training

1. Provide your medical or surgical specialty: ____________________

2. Do you limit your Practice to the specialty stated in Item 1. above? ☐ Yes ☐ No

3. If you have a subspecialty please describe: ____________________

4. Are you Canadian Board Certified? ☐ Yes ☐ No

Medical Specialty in which you are Certified: ____________________

Date of Certification: ________________ Any Recertification Date: ________________

If you are not Canadian Board Certified, do you plan on taking the Board Examination? ☐ Yes ☐ No

5. Provide the following information:

	Specialty	Name of Institution	Province	Date Completed
Medical School				
PGY - 1/Internship				
Residency				
Residency				
Fellowship				
Other				

6. If you graduated from a foreign medical school, are you Certified by the Educational Council For Medical School Graduates? ☐ Yes ☐ No
If Yes, provide the following:

Date of Certification: ____________________ Any Recertification Date: ____________________

7. Provide a summary of where you have practiced your profession since completing your training:

____

____

____

8. Are you a member of any professional societies? ☐ Yes ☐ No
If Yes, provide information:

____

____

9. How many hours of continuing medical education have you taken within each of the last 2 years? ______________

Scope of Practice

1. Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia? ☐ Yes ☐ No
   If Yes, please complete Supplement A

2. Do you perform surgery for obesity? ☐ Yes ☐ No
   If Yes, please complete Supplement A

3. Is general anesthesiology administered for any of the procedures identified in Item 1 & 2 above? ☐ Yes ☐ No
   If Yes:

   By you? ☐ Yes ☐ No

   By an anesthesiologist? ☐ Yes ☐ No

   By a CRNA? ☐ Yes ☐ No

   If administered by a CRNA, is the CRNA directed by or responsible to an Anesthesiologist? ☐ Yes ☐ No
   If not, explain the type of surgery and percentage of your surgeries, or average number of such procedures per month:

   ____

   ____

   Are Harvard Standards, or equivalent, for the administration of all anesthesia adhered to? ☐ Yes ☐ No

4. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise? ☐ Yes ☐ No
   If Yes, please answer the following:

   % of patients that are weight control patients: __________

   Do you Dispense Drugs? ☐ Yes ☐ No
   Name/type of drugs dispensed:

   ____

   Do you use injections for weight control? ☐ Yes ☐ No
   Name/type of drugs injected:

   ____

5. Do you perform consultations on Non-Resident patients from outside of your primary office, including but not limited to the use of telecommunications technology as a medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ☐ Yes ☐ No
   If Yes, please provide complete explanation on last page of application.

6. Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? ☐ Yes ☐ No

   If Yes, do you follow Health Canada Approved Protocols? ☐ Yes ☐ No
   If Yes, describe:

   ____

7. Are you a principal investigator for any clinical trials? ☐ Yes ☐ No

8. What is your total annual patient load? ______________________

9. What is your total annual Non-Resident patient load expected to be this year? ______________

   Actual - first prior year? ______________

   Actual - second prior year? ______________

10. How many hours do you practice each week? ______________________

11. What is your approximate annual income from your practice? (check one)

    ☐ Less than $50,000 ☐ $ 50,000 to $ 99,000
    ☐ $100,000 to $149,999 ☐ $150,000 to $199,999
    ☐ $200,000 to $499,999 ☐ $500,00 or more (estimate): ______________

12. How do you obtain the Non-Resident patients that you treat?

    ☐ Advertising - Radio ☐ Advertising - Other
    ☐ Advertising - Print ☐ Referral - to who? ______________
    ☐ Advertising - Internet

13. Outside of the cost of medical treatment, do you offer any economic or financial incentives to attract patients? ☐ Yes ☐ No
    If Yes, please provide Explanation on last page of application.

14. Are you the Medical Director of a nursing home, clinic, commercial enterprise or other organization? ☐ Yes ☐ No
    If Yes, please provide Explanation on last page of application and attach contract.

15. Are you engaged in or planning to engage in any moonlighting activities? ☐ Yes ☐ No
    If Yes, please provide Explanation on last page of application.

Claims History

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

3. Are you engaged in or planning to engage in any moonlighting activities? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

4. Have you ever been investigated, asked to resign, or been involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited suspended, revoked, placed on probation or been voluntarily surrendered in an province? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulator agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? ☐ Yes ☐ No
If Yes, please provide Explanation on last page of application.

Note: If the applicant does not purchase prior acts coverage from the company there will be no coverage with the company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the applicant's policy, if issued.

Notice to the Applicant – Please Read Carefully

The policy applied for is SOLELY AS STATED INTHE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

Markel is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the Company receives notice is on file with Markel and is considered physically attached to and part of the policy if issued. Markel will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and date effective date of the policy, the Applicant will promptly notify Markel, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

Warranty

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Markel.

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

SUPPLEMENT A - SURGICAL SERVICES

For any of the following procedures that you perform, please indicate where the procedure is performed:
H = Hospital, **O** = Office, **S** = Surgi-center

Procedure	Loc.	Procedure	Loc.	Procedure	Loc.
Abortions - 1st Trimester		Breast Implants or Reductions		Obstetrics	
Abortions - 2nd/3rd Trimester		Catheterization		Prenatal Care	
Acupuncture		Cosmetic Implantation of silicone or other material		Normal Deliveries	
Adenoidectomy Tonsillectomy		Cryosurgery - other than benign lesions		Caesarean Sections	
Anesthesia - Non-obstetrical		Chelation Therapy		VBAC Deliveries	
General		Dermabrasion/Chemical Peels		Open Reduction of Fractures	
Spinal		Dilation & Curettage		Pain Management (describe on last page of app)	
Epidural		Discograms		Plastic - Cosmetic Procedures	
Anesthesia - Obstetrical		Electroconvulsive Therapy		Blepharoplasty	
General		Endoscopic procedures		Collagen Injections	
Spinal		Hair Transplants		Botox Injections	
Epidural		Hyperbaric Medicine		Liposuction < 3500 cc's volume	
Anesthesia - Other		Spinal Surgery (including chemonucleoslysis or percutaneous lumbar discectomy)		Liposuction > 3500 cc's volume	
General		Hysterectomies		Phalloplasty or Penile implants	
Spinal		Laser Skin Resurfacing		Rhinoplasty	
Epidural		Laser Surgery		Silicone Injections	
Angiography		Lymphangiography		Other Plastic/Cosmetic Surgeries	
Angioplasty		Minimally invasive Surgery (explain on last page of app)		Pneumoencephalography	
Anti-aging procedures		Moh's Micrographic Surgery (describe on last page of app)		Radiation Therapy	
Arteriography		Myelography		Radiopaque dye injections	
Assisting in Surgery		Needle biopsies (describe on last page of app)		Refractive Surgery - LASIK, PRK AK, PTK, ICR	

Comments: ____________________

If you perform any of the following procedures, please provide full details of each:

Roux-en-Y:

Number performed in past 12 months: ____________

Number anticipated in the next 12 months: ____________

Number of open cases: ____________

Banding:

Number performed in past 12 months: ____________

Number anticipated in the next 12 months: ____________

Number of open cases: ____________

Gastric Restriction (describe):

Number performed in past 12 months: ____________

Number anticipated in the next 12 months: ____________

Number of open cases: ____________

Do you perform any surgery in your office? ☐ Yes ☐ No
If so, answer the following:

Describe in detail any procedures not identified above:

Is your surgical suite Certified? ☐ Yes ☐ No
If Yes, Certification Body: ____________

Do you perform any surgery in other non-hospital facilities? ☐ Yes ☐ No

Describe in detail any procedures not identified above:

Name Each Facility and provide details:

ADDITIONAL COMMENTS/EXPLANATIONS: