MEDICAL ESTABLISHMENT
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. Have you ever engaged in a similar activity under a different name? ☐ Yes ☐ No
   If Yes, please see Question 6. and provide full details in the same numerical order on a separate sheet.:

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 __________ %

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

____

____

____

7. i) What percentage of funds are generated from:

a) Government / Public __________ %

b) Private funding __________ %

c) Charitable donations __________ %

ii) What are the approximate percentages of patients from:

a) Government / Public __________ %

b) Private funding __________ %

c) Charitable donations __________ %

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:

____

____

____

8. 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) Are you a member of any Association or Professional Body, or registered with any self-regulating Organizations? ☐ Yes ☐ No
If Yes, please state which:

____

ii) Has membership or registration with such, ever been suspended, withdrawn, amended, declined or had conditions attached?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

____

____

9. Does the Establishment have:

i) C.A.T. / M.R.I. Scanners or similar? ☐ Yes ☐ No
If Yes, please provide details of any maintenance agreement.

ii) Medical teaching facilities? ☐ Yes ☐ No

iii) Nursing teaching facilities? ☐ Yes ☐ No

iv) Pathology Laboratories? ☐ Yes ☐ No

v) Any ambulances owned? (Provide number or "None") ____________

vi) Any air ambulances owned / operated? (Provide number or "None") ____________

10. i) Please state the total number of beds and average daily occupancy:

	Number	A.D.O.
Beds		
Bassinets / Cribs / Cots		
I.C.U. / I.T.U.		

ii) Please state the total number of admitted in-patients:

Last year ____________

Please state what, if any, percentage of your patients came from U.S.A. ____________ %

Please state what, if any, percentage of your clients who may be resident in Canada, come from the U.S.A. ____________ %

11. i) Please identify the approximate percentages of procedures performed on ADMITTED in-patients within the following categories:

Accident & Emergency (Addendum 4)* ____________ %

Assisted Conception (Addendum 1)* ____________ %

Clinical Trials (Addendum 2)* ____________ %

Communicable Diseases	______	%
Drug / Alcohol Dependency	______	%
Dental	______	%
Elective Cosmetic	______	%
Elective T.O.P.	______	%
Gender Reassignment	______	%
Geriatric	______	%
Maternity / Obstetrics (Addenda 3 & 4)*	______	%
Organ Transplant	______	%
Paediatric	______	%
Psychiatric	______	%
Tropical Diseases	______	%
Other Minor Surgery	______	%
Intermediate Surgery	______	%
Major Surgery	______	%
Keyhole Surgery	______	%

Where indicated with an * please complete sections of the Addenda as indicated

ii) Please state the number of Operating Theatres: ______

12. Please give details of any procedure(s) performed at any Out Patient Clinic(s) which is/are NOT included in the above information or set out in a separate application. Please specify the approximate number of patients treated and percentage of Gross Fee Income / Sales / Gross Receipts derived during the past Financial year:

	Patients Per Year	% of Total Income
Antenatal Clinic	______	______ %
Assisted Conception	______	______ %
Elective Cosmetic	______	______ %
HIV / HEP (including counseling)	______	______ %
Laser Eye Surgery	______	______ %
Nutrition / Diet / Slimming	______	______ %

	Patients Per Year	% of Total Income
S.T.D.		%
Sports Injury		%
Well Man / Well Woman		%
Other*		%
TOTAL		%

* (please give details) ______________________________

13. **PLEASE NOTE 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 PRACTITIONERS FOR WORK PERFORMED AT THE INSURED, PLEASE SUPPLY A LIST OF ALL DOCTORS FOR WHOM COVERAGE IS REQUIRED STATING THE NAME, DATE OF BIRTH, QUALIFICATIONS AND PRACTICE OF EACH DOCTOR. IN ADDITION TO THIS PLEASE CONFIRM WHETHER OR NOT THE DOCTORS ARE EMPLOYED BY THE INSURED OR SELF-EMPLOYED.

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

	Employed by the Insured	Self-Employed
Non-procedural Physicians:		
Psychiatrists		
Other		
Surgeons:		
Cosmetic		
Orthopedic		
Other		
Anesthetists		
Obstetricians		
Gynecologists		
Lab / Path technicians		
Dentists		
Midwives		
Nurses - Day		
Nurses - Night		
Pharmacists		
Paramedics		

	Employed by the Insured	Self-Employed
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries - Day		
Auxiliaries - Night		
Counsellors		
Directors / Partners / Principals		
Clerical / Administration		
Other (please specify)		

14. 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, refer to the NOTE in Question 13.

15. 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				
HIV / HEP / STD				
Sterilization				

Other (please specify): ______________________________

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

____

16. 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? If "Yes" what procedures are in place? ☐ Yes ☐ No

17. i) Do you have a blood bank? ☐ Yes ☐ No

ii) Please state average number of units of blood or blood products used by your Establishment in any one calendar month:

iii) Is 100% of the above bought or obtained from Canadian Blood Services or Hema Quebec? ☐ Yes ☐ No
If No, please give full details:

iv) Are all blood or blood products tested for transmittable diseases in accordance with Canadian Blood Services or Hema Quebec or an equivalent body prior to use. ☐ Yes ☐ No
If Yes, please list all tests carried out:

If No, please give full details:

Please provide full details of storage facilities and procedures:

18. 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.

19. 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:

____

____

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

Premises Coverage

20. 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?

v) Are precautions / instructions are taken / issued in the use of cleaning solvents or other substances likely to be harmful to health and do you warn users and third parties of these hazards? ☐ Yes ☐ No
If No, please give full details:

21. 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

22. 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>

23. 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:

____

____

24. 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:

____

25. 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:

____

____

26. 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.26 a) OR Q.26 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 26. a) AND/OR 26. 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.

27. 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 26. a) or 26. 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 TRIALS

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 questions 2 and 3 above.

ADDENDUM 3 – MATERNITY/OBSTETRICS

1. Please state the number of Deliveries per annum __________

Including: Multiple Births __________

Healthy Neonatals __________

Stillborn Infants __________

Infants delivered at less than 32 weeks __________

Infants delivered at less than 1501 grams __________

Number of infants admitted to the NICU/SCBU __________

i) From your own Obstetrical Department __________

ii) Transferred from entities outside the control of the Insured __________

2. Is an Obstetrician available "in-house" 24 hours a day? ☐ Yes ☐ No

3. Is a second Obstetrician on call 24 hours per day who is able to attend within 30 minutes? ☐ Yes ☐ No

4. Is a Pediatrician available "in-house" 24 hours per day? ☐ Yes ☐ No

5. Is an Anesthetist available solely to the obstetrical department 24 hours a day? ☐ Yes ☐ No

6. Is a second Anesthetist on call 24 hours per day who is able to attend within 30 minutes? ☐ Yes ☐ No

7. Can emergency Caesarean sections be performed within 30 minutes, 24 hours per day? ☐ Yes ☐ No

8. Can Midwives attend births without an attending Doctor? ☐ Yes ☐ No

9. Can outside Doctors attend their own patients? ☐ Yes ☐ No

10. Please give brief details of the Insured's policy in respect of mother and fetal monitoring:

___

11. Do you offer counseling service for parents following miscarriage, or perinatal death or the birth of handicapped children? ☐ Yes ☐ No

ADDENDUM 3 – EMERGENCY CARE

Please indicate which of the following best describes the extent of emergency care provided by the Insured:
(Please tick box)

i) Comprehensive emergency car is available 24 hours a day and includes anesthetic, medical and surgical services by resident medical staff, with other specialty consultation available within approximately 30 minutes. ☐

ii) A Doctor is always present in the emergency care area with specialty consultation available within approximately 30 minutes. ☐

iii) Emergency care is provided within approximately 30 minutes through a medical staff call roster. ☐

If none of the above, please provide full details.

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: ______________________