



# MEDICAL MALPRACTICE INSURANCE APPLICATION

THIS APPLICATION IS FOR A CLAIMS MADE POLICY

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION WHERE APPLICABLE

- Résumés / Certifications for Principals and Key Employees
- Consent Forms / Waivers / Protocols

## 1. GENERAL INFORMATION

1. Name of Organization or Legal Entity (Applicant) including any subsidiaries:

\_\_\_\_\_ (please show complete name as you wish it to appear on the policy)

2. Address (Not P.O. Box):

\_\_\_\_\_

Website: \_\_\_\_\_

3. How many locations are there? \_\_\_\_\_

Please list all other locations including full address on a separate sheet.

4. Coverage requested:

Limit of Liability:  \$1,000,000  \$2,000,000  \$5,000,000  Other: \$ \_\_\_\_\_

Deductible:  \$1,000  \$5,000  \$10,000  Other: \$ \_\_\_\_\_

Target Premium: \$ \_\_\_\_\_

## 2. CLINIC INFORMATION

5. Type of Organization (please provide full details of all activities):

\_\_\_\_\_

6. Date operations began: \_\_\_\_\_

7. Ownership structure (please identify partners and percentages of ownership):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Within the next twelve (12) months are there plans to obtain another locations or expand operations?  
If YES, where and how? \_\_\_\_\_

YES  NO

9. Name of Principal(s): \_\_\_\_\_

10. Qualifications of Principal(s): \_\_\_\_\_

11. Number of Employees: Full-time: \_\_\_\_\_

Part-time: \_\_\_\_\_

**MEDICAL MALPRACTICE INSURANCE APPLICATION**

12. Please complete the following:

STAFF DETAILS	NEXT YEAR	CURRENT YEAR	LAST YEAR
NUMBER OF FULL TIME PRACTITIONERS			
NUMBER OF PART TIME PRACTITIONERS			
NUMBER OF NURSING STAFF			
NUMBER OF ADMINISTRATION STAFF			
OTHER (describe) _____			

13. If applicable, are all practitioners operating in the Organization licensed/certified to practice in the province?  YES  NO  
 If NO, please provide a reason: \_\_\_\_\_

14. Please provide the numbers of practitioners in the Clinic by category (if applicable):

Audiologists	_____	Laboratory Technicians	_____
Optometrists	_____	Chiropractors	_____
Perfusionists	_____	Physical Therapists	_____
Psychologists	_____	Pulmonary Therapists	_____
Massage Therapists	_____	Registered Pharmacists	_____
X-ray Technicians	_____	Dentists	_____
Gynecologists	_____	Surgeons	_____
General Practitioners	_____	Other (please identify practice):	_____

**PLEASE NOTE THAT THIS PROPOSED INSURANCE WILL NOT INCLUDE COVERAGE FOR ANY PHYSICIAN, DOCTOR, SURGEON OR DENTIST.**

15. Do practitioners carry their own professional liability coverage?  YES  NO  
 If YES, are you seeking entity coverage only?  YES  NO

16. Does the clinic perform any type of surgery?  YES  NO  
 If YES, please provide details: \_\_\_\_\_

17. Please provide the total number of patient or client visits per year:  
 Last 12 months \_\_\_\_\_ Next 12 months \_\_\_\_\_

18. Please provide the Organization's total gross revenue:  
 Last 12 months \$ \_\_\_\_\_ Next 12 months \$ \_\_\_\_\_

19. Please provide average billing per patient/client: \$ \_\_\_\_\_

20. Are any services performed outside of Canada or for patients/clients residing outside of Canada?  YES  NO  
 If YES, please provide details on a separate sheet.  
 What percentage of gross revenues are attributed to non-Canadian clients? \_\_\_\_\_ %

21. Does the Organization attract patients/clients because of reputation in any particular field?  YES  NO  
 If YES, please explain: \_\_\_\_\_

22. Does the Organization own, control or staff one or more of the following:

- Facilities for overnight care?  YES  NO
- Substance abuse program?  YES  NO
- Laboratory?  YES  NO
- Emergency vehicles?  YES  NO
- Pharmacy?  YES  NO

3. QUALITY CONTROL

- 23. Does the Organization have a written quality control program for care and services?  
How are complaints handled?  YES  NO

---

- 24. Does the Organization provide for continuing education programs?  YES  NO
- 25. Is there any research or teaching activities being conducted?  YES  NO
- 26. How are qualifications of new staff checked?  
\_\_\_\_\_
- 27. Is proof of insurance required of subcontracted employees?  
If NO, please explain:  YES  NO

---

- 28. If applicable, do you comply with the current guidelines for the safe handling, collection or disposal of dressings, surgical or clinical waste, sharps and of any blood or blood products?  YES  NO  
If NO to any of the above, provide details:  
\_\_\_\_\_  
\_\_\_\_\_
- 29. How long are records kept? \_\_\_\_\_
- 30. Where and how are records kept? \_\_\_\_\_

4. PRIVACY

- 31. Do you collect, process or maintain private or personal information as part of your business activities?  YES  NO  
If YES, please identify which Personal Identifiable Information is being held:  

Social Security Numbers	<input type="checkbox"/>	Bank Account Information	<input type="checkbox"/>
Credit Card Information	<input type="checkbox"/>	Individual Names and Addresses	<input type="checkbox"/>
Employee Information	<input type="checkbox"/>	Third Party Corporate Information	<input type="checkbox"/>
Personal Health Data	<input type="checkbox"/>	Other (Specify below)	<input type="checkbox"/>

---
- 32. Provide the number of records maintained by the Applicant containing the above information (approx.):  
 0 – 2,500                       2,501 – 5,000                       > 5,000
- 33. Do you comply with the protected health information as defined in provincial legislation in Canada?  YES  NO
- 34. Do you have written procedures in place to comply with laws governing the handling and/or disclosure of such information?  YES  NO
- 35. Do you have a legally reviewed privacy policy?  YES  NO
- 36. Do you share private or personal information gathered from customers (by the Applicant or others) with third parties?  YES  NO
- 37. Have you ever been investigated in respect to safeguards for personally identifiable information?  
If YES, please provide a detailed explanation:  YES  NO  
\_\_\_\_\_  
\_\_\_\_\_
- 38. Have you ever received a complaint about mishandling of someone’s personally identifiable information?  
If YES, please provide a detailed explanation:  YES  NO  
\_\_\_\_\_  
\_\_\_\_\_



For example, but not by way of limitation, an employment practices claim would result from a current or former employee's dissatisfaction with an employment relationship or application process by complaining of discrimination, harassment or unfair treatment.

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.

**7. NOTICE CONCERNING PERSONAL INFORMATION**

---

By purchasing insurance from Beazley Canada Limited, a customer provides Beazley 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 underwriting of policies;
- the evaluation of claims;
- the detection and prevention of fraud;
- the analysis of business results;
- purposes required or authorized by law.

For the purposes identified above, personal information may be disclosed to Beazley's related or affiliated companies and service providers.

Further information about Beazley's personal information protection policy may be obtained by contacting their privacy officer at 416-601-2155.

**8. 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.

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.

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.

SIGNED: \_\_\_\_\_  
(Authorized Representative)

DATED: \_\_\_\_\_

NAME (Please Print): \_\_\_\_\_

TITLE/POSITION: \_\_\_\_\_