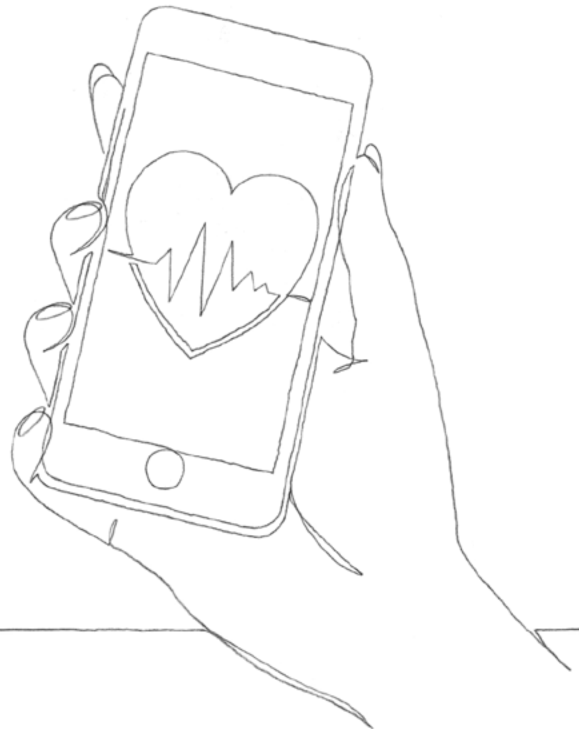
Application form

Beazley | Virtual Care



beazley

Beazley Virtual Care application

- Notice: the policy for which this application is made can be written on a claims made and reported basis or on a claims made/occurrence combined basis, which means that some coverages under the policy apply only to any claim first made against the insured and reported in writing to the underwriters during the policy period or the extended reporting period, if applicable or accidents taking place during the policy period. Amounts incurred as claims expenses shall reduce and may exhaust the limit of liability and are subject to the deductible. Please read this application carefully.

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

Requested attachments:

1. Loss History for the last FIVE years.
2. Most Recent Financial Statements.
3. Sample copy of contract, used by the Applicant in the provision of professional services.
4. Most recent local and/or provincial/federal accreditation agency reports (if applicable).
5. Any marketing brochures or literature detailing services provided.

Section 1 – Applicant/broker information

1. First named insured:

2. Address (street, city, state, postal code):

3. Website address:

4. Mailing address (if different from above):

5. Company years in business: (mm/dd/yyyy) / /

6. Contact (name, phone number, email):

7. Broker firm (street, city, state, postal code):

8. Broker contact (name, phone number, email):

9. Type of entity:

   a. Corporation
   b. Partnership
   c. Non-profit
   d. Individual
   e. Joint Venture
   f. Limited Liability Company
   g. Other (please describe):

10. Parent company (name and address):

11. Additional insureds (please list and include a brief description of relationship with the First Named Insured):

   a.

   b.

   c.

12. Additional named insureds (ownership % must be >50%):

   a.

   b.

   c.

13. Brief description of company operations:

14. Has the company filed for bankruptcy in the last 7 years? Yes No N/A

15. Has the company had any mergers/acquisitions in the last 6 years and/or have any plans in the next 12 months? Yes No N/A

16. Is the company/shareholders/directors/officers/partners/members thereof under any investigation for alleged criminal violations relating to business? Yes No N/A

17. Has the company ever operated under a different name? Yes No N/A

If answered 'Yes', to any questions 15 - 17, please explain here:

Section 2 – Coverage information

18. Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy period	Primary/Xs limit	SIR/Deductible	Carrier	Annual premium	Occurrence or claims made?	Retroactive date

19. Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy period	Primary/Xs limit	SIR/Deductible	Carrier	Annual premium	Occurrence or claims made?	Retroactive date

20. Please provide details of products liability coverage purchased in the last five (5) years to date:

Policy period	Primary/Xs limit	SIR/Deductible	Carrier	Annual premium	Occurrence or claims made?	Retroactive date

21. Please provide details of cyber liability coverage purchased in the last five (5) years to date:

22. Do you currently carry employee benefits liability coverage? Yes No N/A
If 'Yes', what is the employee count, limit, deductible, and retroactive date?

23. Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? Yes No N/A
If 'Yes', please explain.

Section 3 – Professional service/product profile

24. Please provide a full description of services rendered:

25. Operations: (for the previous 12 months please provide a breakout of the services provided, and the percentage of total gross revenues. Total must equal 100%.

Service	Revenue	Percentage

26. Does the applicant anticipate making any significant changes in the services/products provided within the next 12 months? Yes No N/A

If 'Yes', please explain:

27. Does the insured sell or lease any products? Yes No N/A

If 'Yes', please explain:

28. Please state the Applicant's revenue percentage from payment cards in the most recent twelve (12) months: %

29. Please complete the following:

	Projected, next Fiscal/Annual period	Past 12 months; most recent, full-annual	First year prior financial year
Total assets:			
Net assets/equity:			
Long Term Debt:			
Gross revenues:			
Net revenues/income:			
Total cash and cash equivalents			

Section 4 – Products completed operations

30. Are products or parts manufactured outside Canada? Yes No N/A
If 'Yes', what product(s) and where?

31. Are you aware of product(s) sold off-label? Yes No N/A
   a. If so, are off-label products tracked? Yes No N/A
   b. Do you have procedures in place for inhibiting employees from off label promotions? Yes No N/A

32. Are any products repackaged or relabeled? Yes No N/A
If 'Yes', what product(s)?

33. Do product(s) have a Black Box or other significant safety warning label(s)? Yes No N/A
If 'Yes', what product(s)?

34. Are product(s) sold as components of other products? Yes No N/A
If 'Yes', please explain:

35. Have product(s) ever been associated with death/permanent injury or hospitalization? Yes No N/A
If 'Yes', please explain:

36. Has any product(s) been recalled in the past 5 years? Yes No N/A
   a. Are you considering recalling any known or suspected defective products from the market? Yes No N/A

If 'Yes' to either, please explain:

37. Are any products specifically approved for, and used by: minors, pregnant women, cognitively impaired and/or prisoners? Yes No N/A
If 'Yes', what product(s):

38. Have you discontinued any products or services in the last 5 years? Yes No N/A

a. Are you considering discontinuing any product or service? Yes No N/A

If 'Yes' to either, please explain:

39. Is applicant considering introducing any new products or services in the next 12 month? Yes No N/A
If 'Yes', please explain:

40. Do you rent/lease medical equipment? Yes No N/A
If so, what type:

41. Do you repair/install/or service medical equipment? Yes No N/A

If so, are you or your employees factory trained? Yes No N/A

42. Do you comply with the Health Canada's Good Manufacturing Practices (GMP) or equivalent manufacturing standards for your product(s)? Yes No N/A

43. Do you maintain the following records:

a. When and where product was manufactured? Yes No N/A

b. To whom the product was sold and date of sale? Yes No N/A

c. Who supplied the materials for the product? Yes No N/A

d. Change in design/change in advertising? Yes No N/A

Section 5 – Medical professional service/product profile

44. Please provide the number of patient contacts in the previous 12 months and current projection:

Number of visits	Projected, next fiscal/ annual period	Past 12 months; most recent, full-annual	First year prior financial year
Clinic			
Laboratory			
Tele-visits (specify)			
Other (specify)			
Total visits			

45. Does the insured have any beds for overnight stays? Yes No N/A

If ‘Yes’, please list number of beds and average occupancy:

46. Has your facility been surveyed by an accreditation agency within the past three years? Yes No N/A

If ‘Yes’, please list name of agency, date(s) of last survey and any recommendations for implementation, including action taken.

47. Does the insured provide any services outside of the Canada? Yes No N/A

If ‘Yes’, please list countries and provide detail for each:

48. Are medications prescribed? Yes No N/A

If ‘Yes’,” please list the provinces/territories in which you are prescribing medications:

49. Are narcotics prescribed? Yes No N/A

If ‘Yes’, what narcotics and in which provinces/territories?

Section 6 – Medical staff profile

50. Schedule of physicians, surgeon, osteopath, podiatrist, orthodontist, chiropractor, psychiatrist, psychologist or dentist – on staff or contracted: (supply separate sheet if necessary):

Name	Specialty	Board certified	Full Time	Part Time	Hours worked	Volunteer, contracted or employed	Has own malpractice insurance	Medical director	Province/Terr physician holds a license in
		Yes No					Yes No	Yes No	
		Yes No					Yes No	Yes No	
		Yes No					Yes No	Yes No	
		Yes No					Yes No	Yes No	

i. Would you like physicians to be covered under the facility's policy? Yes No N/A

ii. Do any of the above physicians have direct patient care responsibilities? Yes No N/A

If 'Yes', what is the physician's role in providing services for the applicant's facility?

51. Please provide details of all other staff utilized:

Health professional	Employed			Contracted		
	Full time	Part time	Hours	Full time	Part time	Hours
Registered nurses						
Licensed practical nurses						
Licensed vocational nurses						
Nurse practitioners						
Physician assistants						
Certified nursing assistants						
Physical, occupational, and speech therapists						
Home health aides						
Sitters/companions						
Emergency medical technicians						
Paramedics						
Pharmacists						
Technicians						
Social workers						
Other (please provide description)						

Section 7 – Credentialing

52. Are all health professionals credentialed prior to hiring? Yes No N/A

53. Is physician credentialing and privileging formalized and documented? Yes No N/A

54. Are all independent contractors required to maintain insurance with limits equal to your own? Yes No N/A

55. Are physicians required to be board certified in their speciality? Yes No N/A

56. How often are physicians re-credentialed?

57. Prior to hiring any employee, does the applicant verify:
    - i. Education background and training? Yes No N/A
    - ii. Employment references with at least two previous employers? Yes No N/A
    - iii. Criminal record, on a Local, provincial/territorial and National scale? Please indicate which apply:
    - iv. Driving record? Yes No N/A
    - v. Credit record? Yes No N/A
    - vi. Drug tests? Yes No N/A
    - vii. Sex Offender Registry? Yes No N/A

58. Does the applicant keep all information on file and verify its completion prior to employment commencement? Yes No N/A

Section 8 – Exposure data

59. Please indicate the % or # of patient encounters for each type of encounter (Canada, United States, Other Country/ies):

	% or # & Type of encounters		% or # & Type of encounters		% or # & Type of encounters		% or # & Type of encounters
CA		CA		CA		CA	
US		US		US		US	

Section 9 – Telemedicine practice

60. Please describe the equipment, hardware and/or software used for delivery of telemedicine, if applicable:

61. Check all that apply to your Telemedicine-Based Activities:

a.	Telephone consultations with referring physicians (second opinions)	Yes	No	N/A
b.	Remote patient monitoring	Yes	No	N/A
c.	Review and render an opinion regarding images, slides, etc. sent from a distant or remote site	Yes	No	N/A
d.	Real-time, interactive patient treatment, including consultation or supervision of onsite physician	Yes	No	N/A
e.	Real-time, interactive patient treatment, including consultation or supervision of onsite healthcare worker (non-physician)	Yes	No	N/A
f.	Render services in or on behalf of an electronic/virtual intensive care unit	Yes	No	N/A
g.	Remote Surgery and/or procedures on patients who are at a distant or remote site	Yes	No	N/A
h.	Other (please specify)			

62. Please provide a written narrative that describes the nature of your telemedicine practice:

Section 10 – Technology based services

63. Please describe in detail the nature and types of professional and/or technology services the Applicant is engaged in:

64. What are the types of Technology Products developed, manufactured, licensed or sold by the Applicant.

65. Please indicate the Applicant's four largest jobs/projects during the past two (2) years:

Client	Product/Service	Contract revenues for this year / total contract

66. Indicate the percentage of the Applicant's revenue expected this year from the following: (Please answer for all that apply.) Please note that the total must equal one hundred percent (100%).

		Revenue %
a.	Packaged Software Development and Licensing	
b.	Custom Software Development	
c.	Software Maintenance and Support	
d.	Computer and Software	
e.	IT Consulting, Including Consulting on Hardware and/Software System Design/Purchase	
f.	Data and Transaction Processing	
g.	IT and Business Process Outsourcing	
h.	Media Content and Data Sales, Subscriptions and Licenses	
i.	Revenues from ISP and Email services	
j.	Website hosting and collocation services	
k.	Advertising and Referral Revenues	
l.	Telecommunication Services	
m.	Other internet services (please explain)	
n.	Technology Products sales and maintenance (other than software)	
o.	Application Service Provider	
p.	Other services or products (please explain)	
	Total:	**100%**

67. What is the Applicant firm's average size contract in terms of total contract revenue?

68. Does the Applicant have any contracts that represent more than five percent (5%) of the Firm's annual revenues? If 'Yes', please attach details.

Section 11 – Operational controls

69. Does the Applicant have written contracts with all clients the Applicant performs work for or provides products to? Yes No N/A

    If 'Yes', what percentage of the time are they used? %

70. Do all services contracts with customers fully describe the scope of services to be provided? Yes No N/A

71. Do all contracts include how any disputes between the Applicant and the customer will be handled? Yes No N/A

72. Do all services and products contracts include provisions for the following?

    a. Damages Caps Yes No N/A

    b. Disclaimer of Implied Warranties/Rights of Recourse Yes No N/A

    c. Guarantees Yes No N/A

    d. Full Disclaimer of Consequential Damages Yes No N/A

    If 'No', please explain circumstances when a full disclaimer of consequential damages is not provided:

Section 12 – Management of content and privacy exposures

73. Does the Applicant collect, process, or maintain private or personal information as part of its business activities? Yes No N/A

    If "Yes:"

    a. Is any of this information regulated by PIPEDA, Personal Health Information Protection Act (Ontario), Freedom of Information and Protection of Privacy Act, etc or other laws or legislation protecting private or personal information? Yes No N/A

    b. Does the Applicant have written procedures in place to comply with laws governing the handling and/or disclosure of such information? Yes No N/A

    c. Does the Applicant have an appointed privacy officer? Yes No N/A

    d. Does the Applicant have a legally reviewed privacy policy? Yes No N/A

    e. Does the Applicant share private or personal information gathered from customers (by the Applicant or others) with third parties? Yes No N/A

74. Is your practice compliant with the PIPEDA privacy rules regarding data security and electronic transmission of protected health information? Yes No N/A

75. Number of personal records maintained?

Section 13 – Media

76. Does the Applicant have a procedure for responding to allegations that content created, displayed or published by the Applicant is libelous, infringing, or in violation of a third party's privacy rights? Yes No N/A

77. Does the Applicant have a qualified attorney review all content prior to posting? Yes No N/A

    If 'Yes', does the review include screening the content for the following:

    a. Copyright Infringement? Yes No N/A

    b. Trademark Infringement? Yes No N/A

    c. Invasion of Privacy? Yes No N/A

78. Has the Applicant ever received a complaint or cease and desist demand alleging trademark, copyright, invasion of privacy, or defamation with regard to any content published, displayed or distributed by or on behalf of the Applicant? Yes No N/A

Section 14 – Computer & network security

79. a. Has the Applicant suffered any known intrusions (i.e., unauthorized access) of its Computer Systems in the most recent past twelve (12) months? Yes No N/A

    b. If 'Yes', how many intrusions occurred?

    c. If any damage was caused by any such intrusions, including lost time, lost business income, or costs to repair any damage to systems or to reconstruct data or software, describe the damage that occurred, state value of any lost time, income and the costs of any repair or reconstruction:

    d. Describe the response taken by the Applicant to the intrusions:

80. Please indicate which of the following written information systems Policies and Procedures the Applicant has published nd distributed to employees:

    a. information system access regulations and controls,

    b. "acceptable use" standards,

    c. the company's right to monitor employee computer use and activity, including reading e-mails and monitoring website activities,

    d. acceptable e-mail use,

    e. acceptable internet use,

    f. password discipline,

    g. remote access,

    h. incident response, handling, and reporting,

    i. standards of communication for proprietary, sensitive, and confidential materials, and responses to threatening, malicious, or unprofessional communications,

    j. phishing.

81. Does the Applicant conduct training for every employee user of the information systems in security issues and procedures for its Computer Systems? Yes No N/A

    If 'Yes', indicate how frequent such training is provided:

82. Are the Applicant's internal networks and/or Computer Systems subject to third party audit or monitoring (including ethical hacking for security purposes)? Yes No N/A

    If 'Yes', please summarize the scope of such audits and monitoring:

83. Has the Applicant undergone any business merger or acquisition that resulted in the merger of information systems in the most recent past three (3) years? Yes No N/A

    If 'Yes', please provide details:

Section 15 – Computer system access protection

84. Does the Applicant provide remote access to its Computer Systems? Yes No N/A

    If 'Yes',

    a. How many users have remote access?

    b. Is remote access restricted to Virtual Private Networks (VPNs)? Yes No N/A

    c. Do you require multi-factor authentication for remote connections to your computer systems? Yes No N/A

    If 'No', describe the extent to which other remote access is allowed, such as modem dial-in accounts, Remote access Servers (RAS), or dedicated Frame Relay (FR) communications.

85. Please indicate which of the following password disciplines the Applicant enforces via automated system or software settings:

    a. Passwords must contain at least eight (8) characters. If not, what is the minimum number of characters?

    b. Passwords must contain a mix of letters and one or more numbers and/or special characters (*()&%$#).

    c. Passwords must be changed at least every thirty (30) days. If not, how often?

    d. Old passwords may not be re-used.

    e. Passwords may not be a word found in a standard dictionary of the English language.

86. Does the Applicant terminate all associated computer access and user accounts as part of the regular exit process when an employee leaves the company? Yes No N/A

87. Does the Applicant regularly compare all associated computer access and user accounts with some comprehensive employee record, such as payroll lists, to identify unauthorized or "extra" user accounts? Yes No N/A

    If 'No', describe any procedures used to assure that user accounts are valid:

88. Does the Applicant use commercially available firewall protection systems to prevent unauthorized access to internal networks and computer systems? Yes No N/A

89. Does the Applicant use intrusion detection software to detect unauthorized access to internal networks and Computer Systems? Yes No N/A

90. Does the Applicant employ Anti-Virus software? Yes No N/A

    If 'Yes', is it company policy to up-grade the software as new releases/improvements become? Yes No N/A

    If 'No', how often does the Applicant upgrade its Anti-Virus software with new releases?

Section 16 – Data backup procedures

91. Is all valuable/sensitive data backed-up by the Applicant every day? Yes No N/A

If 'No', please describe exceptions:

92. Is at least one complete back up file generation stored and secured off-site from the Applicant's main operations in a restricted area? Yes No N/A

If 'No', describe the procedure used by the Applicant, if any, to store or secure copies of valuable/sensitive data off site:

Confirm frequency of integrity testing of offsite data back-ups.

Section 17 – Data encryption procedures

93. Does the Applicant have and enforce policies concerning when internal and external communication should be encrypted? Yes No N/A

If 'Yes', describe the types of 1) internal and 2) external communications which are encrypted.

94. Does the applicant have and enforce policies concerning encryption for data at rest? Yes No N/A

95. Does the applicant have and enforce policies concerning encryption for mobile devices and media (backup tapes)? Yes No N/A

Section 18 – Legal proceedings

96. Has the Applicant or any director, officer, partner or principle been involved in any of the following:

a.	Criminal action or administrative proceeding charging violation of a federal, provincial/territorial or foreign or regulation?	Yes	No	N/A
b.	Been a party to any lawsuit or other legal proceeding within the past five (5) years?	Yes	No	N/A
c.	Been subject to disciplinary action as a result of professional activities?	Yes	No	N/A

If 'Yes', please provide (on Attachment 'A') a description which includes the venue of the action, the parties, the amount at dispute, the nature of the claim(s), the status of the action(s) and how the action(s) was resolved as to the Applicant, including all costs incurred; including defense expenses.

Section 19 – PCI compliance

97. Please complete the following if you accept payment cards:

How many transactions do you process each year:

a. more than 6 million

b. 1 million to 6 million

c. 20,000 to 1 million

d. less than 20,000

98. What percent of card transactions are: Card Not Present % Card Present %

99. Are you required to submit a Report on Compliance (ROC) or a Self-Assessment Questionnaire (SAQ) to document compliance with the PCI Data Security Standards?

ROC	SAQ – Type C
SAQ – Type A	SAQ – Type C-TV
SAQ – Type A-EP	SAQ – Type D
SAQ – Type B	None of the above
SAQ – Type B-IP	

100. When was your last ROC or SAQ report submitted? (dd/mm/yyyy) / /

101. Are you currently compliant with the PCI Data Security Standards version 3.0? Yes No N/A

If 'No', when do you anticipate being compliant with PCI version 3.0?

102. a. Is a 3rd party payment processing application being used? Yes No N/A

b. Has the application undergone PA-DSS validation? Yes No N/A
If 'No', please list the name and version of software application(s) here:

103. a. Is cardholder data (PAN, CVV) stored or otherwise retained for any purpose after a transaction? Yes No N/A
If so, for how long is card data stored in your system after a transaction?

b. Do you store consumer card data in your systems for future transactions? Yes No N/A

104. Do you employ any of the following: tokenization or end-to-end encryption including encryption of databases) to protect payment card data?
Tokenization
End to end encryption

105. Are employees, administrators, or vendors, with remote access to payment systems or applications authenticated using a 2-factor authentication mechanism? Yes No N/A

106. When did you last check your POS system for malware?

a. How often do you check your POS systems for malware?

b. Have you discovered any malware on your POS system in the last 12 months?

107. Please describe your procedures in place to prevent physical tampering of POS terminals:

108. Please provide a general description of the areas where you are out of compliance?

109. Please describe your remediation efforts to attain compliance with the issues noted above:

110. Please describe any compensating controls that you have implemented:

111. By what date do you plan to attain compliance? (dd/mm/yyyy) / /

Section 20 – Claims information

112. Has any claim or suit ever been made against you or your organization or any employees/staff working on your behalf which it would be subject of this proposed insurance? Yes No N/A

If 'Yes', how many?

Complete a copy of our Supplemental Claim form for each.

113. Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which it would be subject of this proposed insurance? Yes No N/A

If 'Yes', has each of these been reported to the current or any prior insurer? Yes No N/A

How many?

Complete a copy of our Supplemental Claim form for each.

114. Has the applicant or any staff:

a. ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association? Yes No N/A

b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No N/A

c. ever been treated for alcoholism or drug addiction? Yes No N/A

d ever had any provincial/territorial professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? Yes No N/A

If 'Yes', please provide an explanation on any/all incidents.

115. Have any Loss payments (as defined under the proposed insurance) been made on behalf of any proposed Applicant under the provisions of any prior or current errors or omissions, professional liability, media or network security policy or similar insurance? Yes No N/A

If 'Yes', complete a copy of our Supplemental Claim form for each Loss.

The undersigned is authorized by the Applicant and declares that the statements set forth herein and all written statements and materials furnished to the insurer in conjunction with this application are true. Signing of this application does not bind the Applicant or the insurer to complete the insurance, but it is agreed that the statements contained in this application, any supplemental attachments, and the materials submitted herewith are the basis of the contract should a policy be issued and have been relied upon by the insurer in issuing any policy.

This application and materials submitted with it shall be retained on file with the insurer and shall be deemed attached to and become part of the policy if issued. The insurer is authorized to make any investigation and inquiry in connection with this application as it deems necessary.

The Applicant agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, the Applicant will, in order for the information to be accurate on the effective date of the insurance, immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations or authorizations or agreements to bind the insurance

I have read the foregoing application of insurance and represent that the responses provided on behalf of the Applicant are true and correct.

Signature:

Print name:

Position held (Owner, partner, authorized officer): Title:

Date: / /

Attachment 'A' – Application supplemental claim information

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Supplement must be signed and dated by owner, partner or officer.
3. Please read carefully the statements at the end of this supplement.
4. Please type or print in ink.

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim.

Complete one form for each claim/suit, incident or loss.

1. Applicant name

2. Claimant name

3. Name of Individual(s) at your firm/Company involved in Claim:

4. Indicate whether: Claim/Suit Incident
5. Date of alleged error: / /

   Date claim made against applicant: : / /
6. Additional defendants:

7. Current Disposition of claim:

   a. DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)

   b. ABANDONED (no activity from claimant for over 3 years)

   c. WON by defense

   d. WON by claimant:

      Total Paid: $ Amount Paid on your behalf: $

      Indicate whether:

      Court judgment or Out of court settlement

   f. OPEN Claimant's settlement demand: $

      Defendant's Offer for settlement: $

      Insurer's loss reserve: $

8. Name of Insurer:

9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
   a. Alleged act, error or omission upon which Claimant bases claim:

   b. Description of cases and events:

   c. Description of the type and extent of injury or damage allegedly sustained:

   d. If a medical claim provide type of injury claimed:

Emotional Only	Cosmetic
Temporary Disability	Permanent Disability
Death	Other (describe)

10. Explain what action has been taken by you to prevent recurrence of the same type of claim.

I understand information submitted herein becomes a part of my Beazley Virtual Care Policy Application and is subject to the same warranty and conditions.

Signature of Applicant:

Print name:

Position held (Owner, partner, authorized officer): Title:

Date: / /

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.