Victor Canada
500-1400 Blair Place
Ottawa, Ontario K1J 9B8
Telephone 613-786-2000
Facsimile 613-786-2001
Toll Free 800-267-6684
www.victorinsurance.ca

Application

Errors and Omissions Insurance and Commercial General Liability Insurance for Medical Clinics/Alternative Medicine Clinics/ Alternative Medicine Practitioners

Submitting Broker, please complete the following to assist us in processing this submission:

Name of Brokerage: _____

Name of Broker Contact: _____

Brokerage Address: _____ City: _____ Postal Code: _____

For renewal purposes only: Policy Number: _____ ISN (Client's Number): _____

THE APPLICANT

1. Name of Applicant: _____

   Business/Operating Name: _____

   If more than one legal entity, please indicate the relationship between each: _____

   (Please note that an insurance policy cannot be shared unless there is a financial interest.)

2. Form of Business: ☐ Individual ☐ Partnership or Joint Venture ☐ Corporation or Other Organization

3. Website Address (if applicable): _____

4. Please list all locations.

   Address: _____

   _____

5. Date operations began: _____

6. Please indicate the Applicant's gross annual revenue:

   (a) Previous year: $_____

   (b) Anticipated for next year: $_____

   (c) If a new business, please provide estimated income for the next 12 months: $_____

   THIS QUESTION MUST BE ANSWERED.

7. (a) Please indicate the number of visits/consultations/treatments/sessions during the past year: _____

   (b) Do you treat minors? YES ☐ NO ☐

   If yes, do you obtain written parental agreement? YES ☐ NO ☐

8. Schedule of Services – Please complete the attached listing and provide the percentage of income beside each service together with a price list of services.

9. Please indicate the average billing per patient: _____

10. (a) List the name and discipline of every physician, surgeon and dentist working at the clinic and state the name of the professional liability insurer of each.

Name	Professional Designation	Professional Liability Insurer

N.B.: PLEASE NOTE THAT THIS PROPOSED ERRORS AND OMISSIONS LIABILITY INSURANCE FOR MEDICAL CLINICS EXCLUDES THE SERVICES OF PHYSICIANS, SURGEONS AND DENTISTS WHEN THEY CARRY OUT OR NEGLECT TO CARRY OUT AN ACT IN THE PRACTICE OF THEIR PROFESSION.

(b) Please complete the following for ALL employees not listed in question 10. Use a separate sheet if necessary.

Name	Services/Duties	Qualification/Education (include name of institution and if provincially regulated)	Years of Exp.

(c) Are you now or have you, within the past five years, practised subject to any restriction or limitation imposed upon your licence? YES ☐ NO ☐

If yes, please provide details.

(d) Have you ever been disciplined by a licensing body? YES ☐ NO ☐

If yes, please provide details.

11. Does the Applicant provide services or perform activities outside Canada or for clients who are outside Canada? YES ☐ NO ☐

If yes, please provide full details for our review and acceptance, and indicate the services provided as well as the location and the gross annual fees or income from the past year and anticipated for the next year.

INSURANCE COVERAGE - **If you are renewing your policy with Victor, do not complete this section.**

12. (a) Has the Applicant ever previously purchased professional liability or errors and omissions insurance? YES ☐ NO ☐

    (b) If yes, please provide the following details for the last three years:

Insurer	Policy Period	Expiring Premium	Limit	Deductible
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____

    (c) With respect to (b) above, please indicate if such coverage was offered on an occurrence basis or claims-made basis: _____

    If claims-made, what was the retroactive date of the policy (dd/mm/yyyy)? _____

13. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused? YES ☐ NO ☐

    If yes, please provide details.

LOSS EXPERIENCE - **If you are renewing your policy with Victor, do not complete this section.**

14. (a) With respect to the coverage applied for by this application, has the Applicant or any of their employees ever been the recipient of any allegations/claims? YES ☐ NO ☐

    (b) Is the Applicant or any of their employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? YES ☐ NO ☐

    If yes, please provide details of dates, amounts claimed/paid/outstanding, including the nature of the allegations.

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURERS, IT IS 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.

LIMITS REQUESTED

15. Per claim: $_____ Per policy period: $_____ Deductible: $_____

Please note that the proposed insurance will be effective at a date determined by the insurers.

COMMERCIAL GENERAL LIABILITY – **Complete this section only if you require a CGL quotation.**

16. Please list all locations at which business is conducted, providing details indicated below:

Address	Rent or Own	Area (m^2)	Age	Construction (frame, brick, etc.)	No. of Stories	Tenants' Legal Liability Limit Requested
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

If location(s) is owned, please describe other occupancies (if any): _____

_____

_____

17. Please provide a full description of product sales, if any:

Type of Product	Estimated Current Fiscal Year

18. Are all natural health products licensed under Canada Natural Health Products Directorate? YES ☐ NO ☐

If no, please provide a complete explanation.

19. If products are distributed outside Canada, please provide a breakdown of sales for the United States and foreign (indicate country): _____

_____

20. **Limits Requested**

(a) Limit(s) of Liability requested: _____

(b) Property Damage Deductible(s) requested: _____

21. **Extensions**

(a) ☐ Non-owned Automobile Liability

If non-owned automobile coverage is required, please respond to the following questions:

(i) Please indicate the number of employees who regularly drive their own vehicle on company business:

_____

(ii) Please indicate the approximate number of "rental days" in the next 12 months that your employees will rent a vehicle (short term) for the purpose of conducting company business in:

Canada: _____ United States: _____

(b) ☐ Employee Benefits Liability

(c) ☐ Employers' Bodily Injury Liability

22. **Insurance**

(a) Name of Present Insurer: _____

(b) Policy Period: _____

23. Has any insurer cancelled, declined or refused to renew or issue insurance of the type applied for? YES ☐ NO ☐

If yes, please provide details: _____

_____

24. **Claims History**

Have there been any liability claims or potential claims that have come to the Applicant's attention during the past three years? YES ☐ NO ☐

If yes, for each incident, please provide details on the date of the loss, the nature and cause of the claim, the amount claimed, the costs actually incurred (claim investigation, defence costs and damages) and the status of the claim. Please use additional paper if necessary.

APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM

I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to Victor Insurance Managers Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize Victor Insurance Managers Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on Victor's privacy policy, please contact privacypolicyinquiries@victorinsurance.com.

DECLARATIONS AND SIGNATURE

The undersigned Applicant for this insurance declares that, to the best of their knowledge and belief, the statements set forth herein are true and correct, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned agrees that, if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant further agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy.

Name of Applicant (please print)

Signature of Applicant

Date (dd/mm/yyyy)

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Schedule of Services

Medical Clinic

☐ General Family Medicine _____%

Medical Services

☐ Audiologist	_____%	☐ Osteopath	_____%
☐ Chiropodist	_____%	☐ PSW/Care Worker	_____%
☐ Dietician	_____%	☐ Pharmacist	_____%
☐ Eye Laser	_____%	☐ Physiotherapist	_____%
☐ Fertility Clinic	_____%	☐ Prosthetist/Orthotist	_____%
☐ Laser Therapy	_____%	☐ Psychotherapist	_____%
☐ Lab Technician	_____%	☐ Radiographer	_____%
☐ Naturopath	_____%	☐ Rehabilitation Therapist	_____%
☐ Nurse	_____%	☐ Sonographer	_____%
☐ Occupational Therapist	_____%	☐ Speech Therapist	_____%
☐ Optometrist	_____%	☐ Other _____	_____%

Alternative Medicine

☐ Acupuncture	_____%	☐ Iridology	_____%
☐ Acupressure	_____%	☐ Kinesiology	_____%
☐ Alexander Technique	_____%	☐ Laser Hair Removal	_____%
☐ Aromatherapy	_____%	☐ Light Touch Therapy	_____%
☐ Ayurveda	_____%	☐ Massage Therapist (RMT)	_____%
☐ Bach Remedies	_____%	☐ Microdermabrasion/Peels	_____%
☐ Body Wraps	_____%	☐ Music Therapy	_____%
☐ Botox	_____%	☐ Naturopath	_____%
☐ Collagen	_____%	☐ Nutrition Therapy	_____%
☐ Colour Therapy	_____%	☐ Osteopathy	_____%
☐ Colonic Irrigation	_____%	☐ Pigment Removal	_____%
☐ Craniosacral Therapy	_____%	☐ Radionics	_____%
☐ Crystal Therapy	_____%	☐ Reflexology	_____%
☐ Counselling	_____%	☐ Restylane Injections	_____%
☐ Ear Candling	_____%	☐ Rolfing	_____%
☐ Electrolysis	_____%	☐ Shiatsu	_____%
☐ Healing/Reiki	_____%	☐ Skin Tag/Mole Removal	_____%
☐ Herbalism	_____%	☐ Spider Vein Removal	_____%
☐ Homeopathy	_____%	☐ Other _____	_____%

Do you provide any services not listed above? YES ☐ NO ☐

If yes, please provide full details: _____

_____

_____

If gynecological services are rendered at the clinic, please state the percentage of services in relation to overall medical services rendered at the clinic as follows:

(a) gynecology without surgery _____%

(b) gynecology with surgery _____%

(c) gynecology with surgery including abortions _____%

Does the Applicant use single-usage needles? YES ☐ NO ☐

If no, please provide full details of sterilization procedures: _____

_____

_____