

MEDICAL CLINIC INSURANCE APPLICATION

THIS APPLICATION IS FOR A CLAIMS MADE POLICY.

FOR PURPOSES OF THE *INSURANCE COMPANIES ACT (CANADA)*, THIS DOCUMENT WAS ISSUED IN THE COURSE OF LLOYD'S UNDERWRITERS' AND LIBERTY MUTUAL INSURANCE COMPANY'S INSURANCE BUSINESSES IN CANADA.

ALL QUESTIONS MUST BE ANSWERED COMPLETELY. DO NOT LEAVE ANY SPACE BLANK. INDICATE "N/A" IF A QUESTION IS INAPPLICABLE. IF THE SPACE PROVIDED IS INSUFFICIENT TO ANSWER A QUESTION FULLY, PLEASE ATTACH DETAILS ON A SEPARATE SHEET.

1. GENERAL INFORMATION

A) Name of Clinic: _____

B) Address: _____

Web Site Address: _____

C) How many locations are there? _____

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

D) Coverage requested:

| | | | |
|---------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| Limit of Liability: | <input type="checkbox"/> \$1,000,000 | <input type="checkbox"/> \$2,000,000 | <input type="checkbox"/> Other: _____ |
| Deductible: | <input type="checkbox"/> \$5,000 | | <input type="checkbox"/> Other: _____ |
| Employment Practices Liability: | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$250,000 | |

2. CLINIC INFORMATION

A) Type of Clinic (please provide full details of all activities) _____

B) Date clinic's operation began: _____

C) Ownership structure (please identify partners and percentages of ownership): _____

D) Within the next twelve (12) months does the Clinic plan to obtain another clinic or expand the number of locations?
If YES, where and how? _____ YES NO

E) Name of the Chief Executive Officer: _____

F) Name of the Medical Director: _____

G) Name of the Risk Manager/Administrator: _____

H) Number of Employees: Full-time: _____ Part-time: _____

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I) 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 | | | |

J) Are all practitioners operating in the Clinic licensed/certified to practice in the province? YES NO
If NO, please provide a reason: _____

K) Please provide the numbers of practitioners in the Clinic by category:

| | | | |
|-----------------------------------|-------|------------------------|-------|
| 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.

L) Does the clinic perform any type of surgery? If so, please provide details:

M) Please provide the total number of patient visits per year:

Last 12 months _____ Next 12 months: _____

N) Please provide clinic's total gross revenue resulting from medical services:

Last 12 months _____ Next 12 months _____

O) Please provide average billing per patient: _____

P) Does the clinic or any of its practitioners perform activities outside of Canada or for patients residing outside of Canada? YES NO

If so, please provide details on a separate sheet.

Q) Does the Clinic attract patients because of reputation in any particular field? YES NO

If YES, please explain: _____

R) Does the Clinic own, control or staff one or more of the following:

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

3. QUALITY CONTROL

A) Does the Clinic have a written quality control program for care and services? YES NO

How are complaints handled? _____

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- B) Does the Clinic provide for continuing education programs? YES NO
- C) Is there any research or teaching activities being conducted at the clinic? YES NO
- D) How are qualifications of new practitioners/nursing staff checked? _____
- E) Is proof of insurance required of all practitioners operating in the Clinic? YES NO
If NO, please explain: _____
- F) 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? If NO to any of the above, provide details: _____
- G) How long are medical records kept? _____
- H) Where and how are medical records kept? _____

4. PREVIOUS INSURANCE / CLAIM INFORMATION

- A) During the last five (5) years, has the Clinic carried Professional Liability insurance? YES NO
If YES, please complete the following for all previous policies:

| INSURER | TERM | LIMIT | DEDUCTIBLE | PREMIUM |
|---------|------|-------|------------|---------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

- B) When was the first date on which the Clinic purchased continuous claims made coverage? _____
- C) Has the Clinic ever been declined, non-renewed or cancelled by any insurer for Professional Liability insurance? YES NO
If YES, please explain: _____
- D) In the last five (5) years, has the Clinic ever had a claim made against it, or against any practitioner, nurse or employee operating in the Clinic? YES NO
If YES, please provide the following details on a separate sheet:
 - a) Date of claim
 - b) Claimant's name
 - c) Nature of claim
 - d) Amount of indemnity payment and amount of defense costs
 - e) Final dispositions or current status of claim
- E) Is the Clinic aware of any situation or circumstance, which may reasonably result in a claim? YES NO
If YES, please describe in detail: _____
- F) Has any practitioner/nurse ever been investigated or suspended by any governing body? YES NO
If YES, please describe in detail. _____
- G) Has the Clinic, its partners, directors or officers ever had an Employment Practices Liability claim (whether insured or not)? YES NO
If YES, please provide the following details on a separate sheet.
- H) Is the Clinic, its partners, directors or officers aware of any situation, which might give rise to an Employment Practices claim? YES NO
If YES, please describe in detail: _____

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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.

5. NOTICE CONCERNING PERSONAL INFORMATION

By purchasing insurance from Creechurch International Underwriters Ltd. (Creechurch), a customer provides Creechurch 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 Creechurch's related or affiliated companies and service providers.

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

6. 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: _____