

# PRACTITIONER PROFESSIONAL LIABILITY 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 Practitioner: \_\_\_\_\_
- B) Mailing Address: \_\_\_\_\_  
\_\_\_\_\_
- C) Location of Practice: \_\_\_\_\_
- D) Coverage requested:      Limit of Liability:    \$ \_\_\_\_\_ Annual Aggregate: \$ \_\_\_\_\_  
Deductible:                    \$ \_\_\_\_\_

NOTE: If the indemnity paid to a third party claimant exceeds the amount of the Deductible, the Deductible will be waived.

## 2. PROFESSIONAL SERVICES / BACKGROUND INFORMATION

1. Specialization: \_\_\_\_\_
2. Surgery performed: \_\_\_\_\_
3. Other practices: \_\_\_\_\_
4. Years of experience: \_\_\_\_\_
5. Degree held: \_\_\_\_\_
6. School graduated from: \_\_\_\_\_
7. Year graduated: \_\_\_\_\_
8. Other qualifications: \_\_\_\_\_
9. Name of licensing body: \_\_\_\_\_
10. Registration number: \_\_\_\_\_

## 3. QUALITY CONTROL

- A) What patient records are kept? \_\_\_\_\_
- B) How long are records kept? \_\_\_\_\_
- C) Where are they stored? \_\_\_\_\_
- D) How are referrals handled? \_\_\_\_\_

## 4. PREVIOUS INSURANCE / CLAIM INFORMATION

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

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INSURER	TERM	LIMIT	DEDUCTIBLE	PREMIUM

- B) When was the first date on which the Practitioner purchased continuous claims made coverage? \_\_\_\_\_
- C) Has the Practitioner 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 Practitioner ever had a claim made against him/her?  YES  NO  
If YES, please provide the following details on a separate sheet:  
a) Date of claim                      d) Amount of indemnity payment and amount of defense costs  
b) Claimant's name                  e) Final disposition or current status of claim  
c) Nature of claim
- E) Is the Practitioner aware of any situation or circumstance which may reasonably result in a claim?  YES  NO  
If YES, please describe in detail: \_\_\_\_\_

**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: \_\_\_\_\_