

# MEDICAL STUDENT 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' INSURANCE BUSINESS 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 Medical Student: \_\_\_\_\_

B) Foreign Address: \_\_\_\_\_  
\_\_\_\_\_

C) Canadian Address: \_\_\_\_\_  
\_\_\_\_\_

D) Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_

If not Canada, please provide date of entry into Canada and Visa/Passport Number(s): \_\_\_\_\_

Please attach a copy of the Applicant's Curriculum Vitae.

E) Medical School (School at which applicant is a Student): \_\_\_\_\_

Please provide anticipated month/year of graduation: \_\_\_\_\_

F) Medical Elective Placement School: \_\_\_\_\_

Duration of Medical Elective Program (MM/DD/YYYY): From: \_\_\_\_\_ To: \_\_\_\_\_

Please provide a description of the medical elective program(s) that the insured will be participating in: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Supervising Physician: \_\_\_\_\_

(Please complete for all anticipated Medical School Elective Placements).

G) Will you be providing direct patient care?  YES  NO  
If NO, are your activities limited to observation?  YES  NO

H) Coverage requested (please check one of the following):

<b>Limit of Liability:</b>	<b>Deductible:</b>
<input type="checkbox"/> \$1M per claim / \$3M Annual Aggregate	\$2,500
<input type="checkbox"/> \$2M per claim / \$2M Annual Aggregate	\$2,500
<input type="checkbox"/> \$3M per claim / \$3M Annual Aggregate	\$2,500
<input type="checkbox"/> \$5M per claim / \$5M Annual Aggregate	\$2,500

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I) Has the Medical Student ever been declined, non-renewed or cancelled by any insurer for Professional Liability insurance?  YES  NO

If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

J) In the last five (5) years, has the Medical Student 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
- 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

K) Is the Medical Student 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.**

**2. 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 and 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.

**3. 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: \_\_\_\_\_  
(Medical Student)

DATE: \_\_\_\_\_

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

TITRE/POSITION: \_\_\_\_\_