**Medical Clinic Insurance Application- Health Care Questionnaire**

|  |
| --- |
| SECTION 1 –GENERAL INFORMATION |

Legal Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facsimile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  |

1. List of Subsidiaries or Related Entities (such as foundations, auxiliaries or profit-making corporations, which Control, or are Controlled by the Applicant, and for which Coverage is Required:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Type of Clinic and Description of Services;

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many Locations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How long has the Clinic(s) been in operation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Membership in Industry Association(s) or Self Regulating Organizations? [ ]  Yes [ ]  No If yes, please advise.
3. Has your membership ever been suspended, withdrawn, amended, declined or had conditions attached?

[ ]  Yes [ ]  No If yes, please provide details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Current status: For Profit [ ]  or Not-For Profit [ ]
2. Any Anticipated Acquisitions, Expansions or Mergers in the coming year?

[ ]  Yes [ ]  No If yes, please provide details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please provide your Total Gross Revenue:

 For Profit

I. For the past Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

II. Estimate for the current Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not for Profit

I. For the past Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

II. Estimate for the current Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What percentage of funds is generated from the following?
2. Government/Public \_\_\_\_\_\_\_\_\_\_\_\_\_\_%
3. Private Funding \_\_\_\_\_\_\_\_\_\_\_\_\_\_%
4. Charitable Donations \_\_\_\_\_\_\_\_\_\_\_\_\_\_%

|  |
| --- |
| SECTION 2 – PROFESSIONAL & GENERAL LIABILITY  |

11. Describe the type of facility:

[ ]  Surgical Centre: [ ]  Orthopedics [ ]  Gynecology

 [ ]  Ophthalmology [ ]  Gastro-Intestinal

 [ ]  Plastic Surgery [ ]  Hair Transplant

 [ ]  Cosmetic Surgery [ ]  Dental Surgery

[ ]  Other (please specify)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Diagnostic Centre: [ ]  X-Ray [ ]  Colonoscopy

 [ ]  CAT Scan [ ]  Mammography

 [ ]  MRI [ ]  Other (please specify)

 [ ]  Blood Lab \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Medical Clinic: [ ]  General Medical Practice [ ]  Family Health Team

 [ ]  Urgent Care Centre [ ]  Community Health Centre

 [ ]  Walk-In Clinic [ ]  Holistic Wellness Centre

 [ ]  Spa & Wellness Centre [ ]  Men’s Health Clinic

 [ ]  Woman’s Health Clinic [ ]  Children’s Clinic

 [ ]  Addiction & Abuse Centre [ ]  Dietary & Nutrition

[ ]  Other (please specify)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please provide the breakdown of all services offered, including percentage splits across the different areas ;

|  |  |
| --- | --- |
| Services Offered  | Breakdown - Percentage of Services Offered |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. What type of Dietary/Nutrition plans and or programs that are provided by the clinic?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are Dietary/Nutrition plans provided to clients based on healthcare requirements or primarily for weight loss purposes only?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Does the clinic supply diet medicines, metabolic and or sliming aids? [ ]  Yes [ ]  No

 If yes, please provide a list of items

1. Employees – Total Number of Employees:

|  |  |  |
| --- | --- | --- |
| Administrator(s) \_\_\_\_\_\_ | Health Care Aids/PSW \_\_\_\_\_\_ | Social Workers/Counsellors \_\_\_\_\_\_  |
| Director of Care \_\_\_\_\_\_  | Maintenance Staff \_\_\_\_\_\_ | Pharmacists \_\_\_\_\_\_ |
| Medical Director \_\_\_\_\_\_  | Occupational Therapists \_\_\_\_\_\_ | Massage Therapists \_\_\_\_\_\_ |
| Other Admin Staff \_\_\_\_\_\_  | Physiotherapists \_\_\_\_\_\_ | Paramedics/EMS \_\_\_\_\_\_ |
| RNs – General \_\_\_\_\_\_ | Chiropractors \_\_\_\_\_\_ | Recreation Therapists \_\_\_\_\_\_ |
| RN(EC) Nurse Practitioner \_\_\_\_\_\_ | Dieticians/Nutritionists \_\_\_\_\_\_ | RPNs/LPNs \_\_\_\_\_\_ |
| Audiologists \_\_\_\_\_\_ | X-ray Technicians \_\_\_\_\_\_ | Gynecologists \_\_\_\_\_\_ |
| General Practitioners \_\_\_\_\_\_ | Surgeons \_\_\_\_\_\_ | Dentists \_\_\_\_\_\_ |

16. Are your Employees covered under Worker’s Compensation? [ ]  Yes [ ]  No

17. Are all practitioners operating in the Clinic licensed/certified to practice in the province? [ ]  Yes [ ]  No

 If No, please provide a reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Do you ensure and record that all Registered Medical (Doctors & Nurses included) and Dental Practitioners are members of a Medical/Dental Association/Organization and fully insured for their own Malpractice? [ ]  Yes [ ]  No

**PLEASE NOTE THAT THIS APPLICATION FOR COVERAGE WILL NOT INCLUDE MEDICAL MALPRACTICE FOR ANY PHYSICIAN,**

**DOCTOR, SURGEON, CJIROPRACTOR, DENTIST AND OR DENTAL SURGEON.**

19. Does the clinic/facility require coverage for Registered Nurses and other medical professionals, other than the above noted practitioners?

20. Will any Registered Nurses prescribe any medications to patients? [ ]  Yes [ ]  No if yes, please provide details;

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Are your patients primarily Canadian? [ ]  Yes [ ]  No

21. Do any of your services provided extend to patients abroad? [ ]  Yes [ ]  No

1. Percentage of Canadian Patients: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Percentage of US Patients: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Percentage of Worldwide Patients: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. What is the average billing per patient? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. How many patient visits annually? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Does the clinic perform any type of surgery? [ ]  Yes [ ]  No

 *If yes, please provide a list of surgeries provided.*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25. Does the clinic provide birthing services? [ ]  Yes [ ]  No

 If yes, how many births per year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

26. Does your clinic or any of its practitioners perform activities outside of Canada or for patients residing outside of Canada? [ ]  Yes [ ]  No *If yes, please provide details:*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. Does the clinic attract patients because of reputation in any particular field? [ ]  Yes [ ]  No

 *If yes, please explain:*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28. Please indicate total number of beds and daily occupancy:

* Beds Number \_\_\_\_\_\_\_\_\_\_\_ % Daily Occupancy \_\_\_\_\_\_\_\_\_\_\_
* Cribs Number \_\_\_\_\_\_\_\_\_\_\_ % Daily Occupancy \_\_\_\_\_\_\_\_\_\_\_
* Intensive Care Unit Number \_\_\_\_\_\_\_\_\_\_\_ % Daily Occupancy \_\_\_\_\_\_\_\_\_\_\_
* Critical Care Unit Number \_\_\_\_\_\_\_\_\_\_\_ % Daily Occupancy \_\_\_\_\_\_\_\_\_\_\_

 29. Please indicate all Procedures, Protocols and or current Programs:

|  |
| --- |
| Employment Screening: |
| Use of Independent Contractors: |
| Any Volunteer Activities: |
| Procedures for Residential Admission, Ongoing Assessment: |
| Complaints: |
| Fall Prevention Program: |
| Wandering & Elopement Prevention: |
| Smoking Policy: |
| Evacuation Plan & Fire Drill: |
| Medication Administration: |
| Abuse Policy/Protocols: |
| Infection Control Program: |
| Special Events & Fundraising: |
| Counseling Services: |
| Risk Management Program: |
| Managing Systems - Last Updated & Reminders: |

30. Does the clinic/facility employ the services of a risk managing consultant in order to reduce risks of litigation against the clinic or their physicians? [ ]  Yes [ ]  No *if yes, please provide details;*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 31. Are all your Patient/Client Records stored? [ ]  Yes [ ]  No

 30. How long are your patient records stored and what type of storage medium is used?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 31. Please indicate which limit(s) and deductible options of Medical Professional Liability and Commercial General Liability you require quotations for:

Limit Options: [ ]  $1 Million [ ]  $2 Million [ ]  $3 Million [ ]  $4 Million [ ]  $5 Million

Deductible Options: [ ]  1,000 [ ]  2,500 [ ]  $5,000 [ ]  $10,000

|  |
| --- |
| SECTION 3 – PRIVACY & CONSENT |

**Declarations & Warranty**

**The undersigned declares:**

The applicant(s) have reviewed all parts and attachments of this application and acknowledges that all information is true and correct and understands that this application for insurance is based on the truth and completeness of this information. Where (a) an applicant for this contract gives false information to the prejudice of the Insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein, or (b) the applicant contravenes a term of the contract or commits a fraud, or (c) the applicant willfully makes a false statement in respect of a claim, coverage may be voided by the insurer and the applicant’s right of recovery may be forfeited.

The applicant acknowledges providing personal information in this document and otherwise and may in the future provide further personal information. Some of this personal information may include, but is not limited to my credit information and claims history. I authorize my broker or insurance company to collect, use and disclose any of this personal information, subject to the law and my broker’s or insurance company’s policy regarding personal information, for the purpose of communicating with me, assessing my application for and underwriting my policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

The applicant declares that to the best of their knowledge the statements set forth herein are true. Signing of this application does not bind the Applicant or company to complete the insurance.

|  |  |
| --- | --- |
| Print Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

IMPORTANT: This report and quotation contains proprietary and original material which, if released, could be harmful to the competitive position of Aon Reed Stenhouse Inc. Accordingly, this document including its specifics may not be copied or released to third parties without Aon's consent.