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

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| SECTION 1 –GENERAL INFORMATION |

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

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

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

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

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

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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:

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1. Type of Clinic and Description of Services;

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

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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 Has your membership ever been suspended, withdrawn, amended, declined or had conditions attached?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.

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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.

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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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_%

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| 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 ;

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| --- | --- |
| Services Offered | Breakdown - Percentage of Services Offered |
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1. What type of Dietary/Nutrition plans and or programs that are provided by the clinic?

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

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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:

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| --- | --- | --- |
| 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;

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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.*

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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:*

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

*If yes, please explain:*

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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:

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| 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?

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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

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| 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.

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

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