HEALTHCARE - MEDICAL MALPRACTICE APPLICATION

This is an application for a medical malpractice liability policy and the purpose of this application is for us to find out more about your company. All material information should be declared to us but note that completion of this application does not oblige either party to enter into a contract of insurance.

Please be aware that certain coverage under this policy operates on a claims-made basis. This means that for a claim to be covered, it must be made against the Insured and reported to us during the policy period. Additionally, claims related to any actual or alleged wrongful act that occurred before the Retroactive Date will not be covered.

WHO SHOULD COMPLETE THIS APPLICATION

The person completing this application should be a senior staff member at the company. They must verify that they have consulted with other senior managers and colleagues responsible for arranging the insurance to ensure that all questions are answered accurately and thoroughly. Once finished, return the completed application to your insurance broker.

HOW TO COMPLETE THIS APPLICATION

Please complete all questions. If additional space is required for any response, please continue your response in the Additional Information section on the last page of the application.

Please note that the application must be signed and dated to be considered complete.

SECTION 1 - APPLICANT INFORMATION

1. Applicant's name: _____

2. Applicant's address: _____

3. Phone: _____ Email: _____

4. Website: _____

5. Date entity was established (mm/dd/yyyy): _____

6. Location address (if different from mailing address above):
_____

7. List of additional locations (if applicable)

Location #	Full address

8. Applicant is: ☐ A corporation ☐ A partnership ☐ An individual

9. Applicant is: ☐ A clinic ☐ An association/group ☐ An individual practitioner

10. Applicant is: ☐ For profit ☐ Not for profit

SECTION 2 - BUSINESS OPERATIONS

1. Please briefly describe the nature of your business operations:

_____

_____

_____

2. Will the applicant be providing any new services or treatments not previously provided over the next 12 months? ☐ Yes ☐ No
If Yes, please provide additional information:

_____

3. Does the applicant provide services to individuals under the age of 18? ☐ Yes ☐ No
If Yes, is parental consent obtained? ☐ Yes ☐ No

4. Does the applicant perform services outside of Canada? ☐ Yes ☐ No
If Yes, please provide additional information:

_____

5. Does the applicant provide services to non-Canadian Residents? ☐ Yes ☐ No
If Yes, please provide additional information:

_____

If Yes, does the applicant utilize the Canadian Medical Protective Association (CMPA) Jurisdictional Waiver? ☐ Yes ☐ No

6. Does the applicant provide or are they in any way involved in the services outlined below?

Description of service	
Administering of drugs/supplements	☐ Yes ☐ No
Clinical trials (including clinical research)	☐ Yes ☐ No
Correctional facility/penitentiary	☐ Yes ☐ No
Diagnostic imaging services	☐ Yes ☐ No
Dispensing of drugs/supplements	☐ Yes ☐ No
Gender affirming care	☐ Yes ☐ No
Hormone replacement therapy (HRT)	☐ Yes ☐ No
Hypnosis	☐ Yes ☐ No
Invasive surgical procedures	☐ Yes ☐ No
Laboratory testing	☐ Yes ☐ No
Needle exchange program	☐ Yes ☐ No
Obstetrics/fertility services/gynecology	☐ Yes ☐ No
Operating emergency vehicles	☐ Yes ☐ No
Overnight care	☐ Yes ☐ No
Patient transportation	☐ Yes ☐ No
Product sales	☐ Yes ☐ No
Teaching/medical training/continuing education programs	☐ Yes ☐ No

7. If the applicant selected yes to any of the above, please provide additional information:

_____

_____

_____

SECTION 3 - COVERAGE & REVENUE

** Please state all coverage limits & revenues in Canadian dollars ($).*

1. Limit of liability required: ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐ Other: _____

2. Deductible: ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: _____

3. Please complete the below table with respect to gross revenue from your operations:

Country	Revenue ($) from previous 12 months	Revenue ($) anticipated for next 12 months
Canada		
USA		
Rest of world		
Total		

4. For the gross revenue indicated in question 3, please provide the estimated percentage of revenue generated from each of the services you will be providing.

Description of service	% of total revenue	Number of patient visits from previous 12 months	Number of patient visits anticipated for next 12 months

SECTION 4 - RISK MANAGEMENT

1. Please select all practices currently in place and indicate when each was last reviewed.

	Risk management protocol	Updated (mm/dd/yyyy)
☐	A formal, written risk management program that includes documented, organization-wide incident reporting procedures.	
☐	A policy or procedure for medical record retention (electronic or paper)	
☐	A patient complaint management process with escalation to senior leadership	
☐	Formal processes for hiring, onboarding, performance management, and training of all staff and independent practitioners	
☐	A written procedural manual for employees that includes guidance on handling abuse allegations or complaints	

SECTION 5 - PRACTITIONER DETAILS

Practitioner	Number full time	Number part time	Do they carry their own professional liability coverage (Yes/No)	Employee or independent contractor
Health professional				
Acupuncturist				
Aestheticians				
Audiologist				
Chiropractors				
Counsellors				
Dentists				
Gynecologist				
Laboratory technician				
Midwives				
Nurses – Nurse practitioner				
Nurses – Registered nurses				
Nurses – Registered practical nurse/ licensed practical nurse				
Nutritionist/dietician				
Occupational therapists				
Opticians				
Optometrists				
Osteopaths				
Paramedics				
Personal support workers (PSW's)				
Pharmacists				
Physician/general practitioners				
Physiotherapists				
Podiatrists				
Psychologists				
Registered massage therapist (RMT)				
Social Workers				
Other (please provide additional details): _____ _____				
Other (please provide additional details): _____ _____				
Non-health professional				
Administrative staff/clerical staff				
Other (please provide additional details): _____ _____				
Other (please provide additional details): _____ _____				

1. Do all physicians and medical practitioners carry their own professional liability insurance, either through the Canadian Medical Protective Association (CMPA) or another appropriate governing body? ☐ Yes ☐ No

2. Is proof of professional liability insurance obtained and reviewed annually as part of the Applicant's credentialing process? ☐ Yes ☐ No

3. Are all practitioners in good standing with their respective regulatory or professional associations? ☐ Yes ☐ No
   If No, please provide additional information on the last page of the application.

4. Has any employee, contractor, or healthcare professional ever been subject to a complaint, investigation, or disciplinary action by a regulatory body? ☐ Yes ☐ No
   If Yes, please provide additional information on the last page of the application.

5. Does the Applicant provide services to professional athletes? ☐ Yes ☐ No
   If Yes, please provide additional information on the last page of the application.

6. Are reference checks conducted for all employees, independent contractors and volunteers prior to hiring? ☐ Yes ☐ No

7. Are criminal background checks conducted for all employees, independent contractors and volunteers prior to hiring? ☐ Yes ☐ No

8. Does the insured have formal written abuse protocols? ☐ Yes ☐ No
   If Yes, are these protocols required to be reviewed and signed by all employees, independent contractors and volunteers annually? ☐ Yes ☐ No

9. For applicants working with vulnerable persons, is a vulnerable sectors check (VSC) completed? ☐ Yes ☐ No

10. Please list all professional associations the Applicant is currently a member of:
    _____

SECTION 6 - INSURANCE HISTORY & CLAIMS INFORMATION

1. Are you aware of any loss or damage, whether covered by insurance or not, that has occurred to any of the Companies to be insured (or to any existing or previous business of the partners or directors of the Companies) in the past 5 years? ☐ Yes ☐ No
   If Yes, please attach full details including an explanation of the background of events, the maximum amount involved/claimed, the status of the claim(s) or circumstance(s) and any reserve(s) or payment(s) made by the Applicant and/or by Insurers, and the dates of all developments and payments.

2. Are you aware of any circumstances that might lead to a claim against any of the companies to be insured or any of their partners or directors? ☐ Yes ☐ No

3. Have any claims or cease and desist orders been made against any of the companies to be insured, or their partners or directors? ☐ Yes ☐ No

4. Have any partners or directors of the Companies to be insured been found guilty of criminal, dishonest, or fraudulent activities, or been investigated by any regulatory body? ☐ Yes ☐ No

SECTION 7 - DECLARATIONS

By signing, I consent to Revau collecting, using and disclosing my personal information (including, where applicable, financial and/or credit information) for the analysis and management of my insurance application, including disclosure to authorized third parties (insurers, reinsurers and service providers). I acknowledge that my personal information may be processed or stored outside my province or outside Canada and that I may exercise my rights of access, correction and withdrawal of consent, subject to applicable obligations.

I declare that after proper enquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact. I agree that this Application Form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon. I undertake to inform the Insurer of any material alteration to these facts occurring before the completion of the contract.

The undersigned agrees that by signing below, they are affirming the conditions and statements set forth in the Medical Malpractice Liability Insurance Application.

Name of person completing this application: _____ Position: _____

Applicant's signature _____ Date: _____

Please send the completed, signed and dated application to underwriting@revau.com.

SECTION 8 - ADDITIONAL INFORMATION

1. Please declare all relevant information that is are not mentioned in this application.

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