Vailo

Medical Malpractice Liability Application

Vailo Insurance Services Ltd

Suite 430 – 250 Newport Drive,
Port Moody, BC V3H 5H1

Phone: 604.829.3811
Toll Free: 1.877.787.6737

Vailo

MEDICAL MALPRACTICE LIABILITY APPLICATION

APPLICATION FOR INSURANCE

PLEASE READ CAREFULLY: This is an application form for **Claims made policy**. All questions must be answered completely. If there is no answer, write "none" or "n/a" in the space provided. Where space provided is insufficient to fully answer, please use separate page.

Name of Applicant(s): _____

Mailing Address: _____

Website Address: _____

Date Established (Month/Day/Year): _____

Applicant is: ☐ Individual ☐ Partnership ☐ Corporation

Location(s) of Branch Office(s): _____

Limit of Liability Required: ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐ Other _____

Deductible Required: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ Other _____

Number of Employees: **Canada** _____ **USA** _____ **Other** _____

Please indicate the Applicant's gross annual revenue:

Previous Year $	Anticipated $

It the applicant provides their services to clients outside of Canada, please state the percentage and describe the services provided:

Type of Service	Country	% of Revenue

Please confirm for which discipline(s) you require cover:

Complementary Therapy Activities

☐ Acupuncture	☐ Aromatherapy	☐ Chinese Medicine	☐ Colonic Hydrotherapy
☐ Counselling	☐ Crystal Therapy	☐ Healing/Reiki/Dowsing etc	☐ Herbalism
☐ Hopi Ear Candles	☐ Iridology	☐ Kinesiology	☐ Massage *
☐ Manipulative Therapy	☐ Naturopathy	☐ Neuro Linguistic Programming	☐ Nutrition Therapy
☐ Pilates	☐ Polarity Therapy	☐ Psychotherapy	☐ Reflexology
☐ Yoga			

Aesthetics

☐ Botulinum Toxin	☐ Chemical Peels *	☐ Dermal Fillers *	☐ Laser/IPL *
☐ Laser Lipolysis	☐ Mesotherapy	☐ Teeth Whiting *	

Other – Please Specify*: _____

Medical Disciplines

☐ Audiologist	☐ Cardiologist	☐ Dentists*	☐ Dermatologist
☐ Dietician	☐ Endocrinologist	☐ First Aider	☐ General Practitioner
☐ Gynecologists	☐ Hematologist	☐ Immunologist	☐ Medical Lab Technician
☐ Microbiologist	☐ Neurologist	☐ Nuclear Medicine	☐ Nurse
☐ Nutritionist	☐ Occupational Therapist	☐ Oncologist	☐ Ophthalmologist
☐ Optometrist/Optician	☐ Orthodontist*	☐ Orthopedics*	☐ Pediatrician
☐ Paramedic	☐ Pathologist	☐ Perfusionist	☐ Pharmacist
☐ Physiologist	☐ Physiotherapist	☐ Physicians	☐ Prosthetist/Orthotist
☐ Psychiatrist	☐ Radiographer	☐ Radiologist	☐ Sonographer
☐ Speech Therapist	☐ Surgeon*	☐ Urologist	☐ Venereologist

Other – Please Specify*: _____

Qualifications

Please confirm if you are qualified and/or accredited to perform the above declared activities: ☐ Yes ☐ No

Please provide details of any recognized qualification(s) held. Proof may be required by the Underwriters:

_____

_____

_____

_____

_____

Please tick the appropriate box if you are qualified and/or hold a license to practice any of the following:

☐ Nurse ☐ Doctor ☐ Dentist ☐ Beautician/NVQ 3

Other – Please Specify*: _____

Has your membership or registration with a licensing/registration body ever been refused, suspended, withdrawn or had conditions imposed? ☐ No ☐ Yes

If yes, please explain: _____
_____
_____

Please provide your total gross income based on your activity(s) for which you require cover. If this is a new business please provide an estimated figure: Previous Year _____ Next Year (Estimate) _____

Please provide the following details of all Professional Liability / Commercial General Liability carried in the past.

Insurer	Expiry Date	Limit	Deductible	Premium
			$	$
			$	$
			$	$
			$	$

When was the first date on which the Applicant purchased continuous claims made coverage? _____

Has the Applicant ever been declined, non-renewed or cancelled by any insurer for Professional Lability / Errors & Omissions Insurance? ☐ No ☐ Yes

If yes, please explain: _____
_____
_____

In the last five years, has the Applicant ever had a claim made against them? ☐ No ☐ Yes

If *YES, please provide the following details on a separate page, and Include:

(a) Date of Claim
(b) Claimant's Name
(c) Nature of Claim
(d) Amount of Indemnity Payment and Defense Costs

Does the Applicant, or any of the Applicant's employees, have knowledge or information of any act, error, omission or circumstance which might reasonably be expected to give rise to a claim? ☐ No ☐ Yes

If yes, please explain: _____
_____
_____

CLAIMS HISTORY

Please provide details (dates, nature of claim, amounts, status) of all claims that you have experienced in the past five years.

_____
_____
_____
_____
_____
_____
_____

APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM

I hereby acknowledge that the information collected in the Application form is acquired by my Insurance broker to be transmitted to Vallo Insurance Services Ltd. for the sole purpose of obtaining an Insurance policy, and will be kept confidential.

Moreover, I authorize Vallo Insurance Services Ltd., its Insurers or service providers to:

- Conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation.
- In the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purpose of investigating, defending, negotiating or settling any claims as required.

DECLARATION AND SIGNATURE

The undersigned Applicant for this Insurance declares that, to the best of their knowledge and belief, the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned further agrees that if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the Insurance, the undersigned Applicant agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy.

Name of Applicant (Please Print): _____

Signature of Applicant: _____ Date (DD/MM/YYYY): _____