INSTRUCTIONS
Complete all sections in full — incomplete applications may delay quoting. Attach additional sheets where required and reference the applicable section. Broker should review prior to submission.

SECTION A — APPLICANT DETAILS

LEGAL NAME OF APPLICANT / NAMED INSURED

OPERATING / TRADE NAME (IF DIFFERENT)

BUSINESS ADDRESS (STREET)

CITY

PROVINCE / STATE

POSTAL / ZIP

PRIMARY CONTACT NAME

TITLE / ROLE

PHONE NUMBER

EMAIL ADDRESS

WEBSITE URL

YEAR PRACTICE ESTABLISHED

BUSINESS NUMBER / TAX ID

PRACTICE STRUCTURE (SELECT ALL THAT APPLY)

- ☐ Individual / Solo Practitioner
- ☐ Group Practice (same discipline)
- ☐ Multi-Disciplinary Clinic
- ☐ Medical Spa / Aesthetic Clinic
- ☐ Mental / Behavioural Health Practice
- ☐ Home Health / Mobile Services
- ☐ Pharmacy / Dispensary
- ☐ Rehabilitation Centre
- ☐ Urgent Care / Walk-in Clinic
- ☐ Non-Profit / Community Health
- ☐ Other (describe below)

IF 'OTHER', DESCRIBE PRACTICE STRUCTURE / ENTITY TYPE

PROVINCE / STATE OF INCORPORATION

SECTION B — OPERATIONS & SERVICES

DESCRIPTION OF SERVICES PROVIDED

DESCRIBE ALL SERVICES / TREATMENTS OFFERED BY THE PRACTICE

REVENUES

LAST FISCAL YEAR GROSS REVENUE ($)

ESTIMATED CURRENT YEAR REVENUE ($)

FISCAL YEAR END (MM/DD)

GEOGRAPHIC REVENUE BREAKDOWN (MUST TOTAL 100%)

CANADA (%)

USA (%)

OTHER — DESCRIBE

OTHER (%)

SECTION B — OPERATIONS & SERVICES (continued)

REVENUE BY SERVICE (MUST TOTAL 100%)

Allocate approximate % of total revenue to each service / treatment provided.

SERVICE / TREATMENT DESCRIPTION	% OF REVENUE	NOTES (E.G. VOLUME, PATIENT POPULATION)

SECTION C — PERSONNEL & LICENSED PROFESSIONALS

List all practitioners providing services under or on behalf of the practice (employed, contracted, locum).

DESIGNATION / ROLE	#	OWN COVERAGE?		SERVICES PROVIDED BY THESE PRACTITIONERS
Medical Doctor (MD / DO)		☐ Y	☐ N	
Specialist MD (specify below)		☐ Y	☐ N	
Nurse Practitioner (NP)		☐ Y	☐ N	
Registered Nurse (RN)		☐ Y	☐ N	
Licensed Practical Nurse (LPN)		☐ Y	☐ N	
Physiotherapist (PT)		☐ Y	☐ N	
Chiropractor (DC)		☐ Y	☐ N	
Massage Therapist (RMT)		☐ Y	☐ N	
Naturopathic Doctor (ND)		☐ Y	☐ N	
Psychologist / Counsellor		☐ Y	☐ N	
Social Worker (RSW)		☐ Y	☐ N	
Pharmacist (RPh)		☐ Y	☐ N	
Optometrist / Optician		☐ Y	☐ N	
Aesthetician / Cosmetic Tech		☐ Y	☐ N	
Midwife / Doula		☐ Y	☐ N	
Other (specify below)		☐ Y	☐ N	

SECTION C — PERSONNEL (continued)

SPECIALIST MD — SPECIFY SPECIALTY / SPECIALTIES

OTHER DESIGNATION(S) — SPECIFY

TOTAL LICENSED PROFESSIONALS

TOTAL NON-CLINICAL / ADMIN STAFF

TOTAL CONTRACTORS / LOCUMS

TOTAL LOCATIONS OPERATED

LICENSING & REGULATORY STANDING

Are all licensed professionals properly licensed in their jurisdiction(s) and in good standing with their governing regulatory body?	☐ Yes	☐ No
Are any licensed professionals currently subject to investigation, supervision, licence suspension / restriction, disciplinary action, or conditions imposed by a regulatory body?	☐ Yes	☐ No
Are written employment or contractor agreements in place for all clinical providers?	☐ Yes	☐ No
Are credentials, qualifications, and references verified for all new practitioners upon hire?	☐ Yes	☐ No
Are credential checks repeated at regular intervals (e.g. annually)?	☐ Yes	☐ No

IF 'NO' TO ANY OF THE ABOVE, PROVIDE FULL DETAILS

SECTION D — PATIENT CARE & RISK MANAGEMENT

Are written informed consent forms obtained from patients / clients prior to all procedures or treatments?	☐ Yes	☐ No
Are patient / client records maintained for all consultations and treatments?	☐ Yes	☐ No
Are records retained in accordance with applicable jurisdictional retention requirements?	☐ Yes	☐ No
Are emergency protocols in place for adverse patient reactions or medical emergencies?	☐ Yes	☐ No
Is a formal patient complaint and grievance procedure in place?	☐ Yes	☐ No
Does the practice conduct regular staff training on patient safety and clinical protocols?	☐ Yes	☐ No

IF 'NO' TO ANY OF THE ABOVE, PROVIDE FULL DETAILS

SECTION D — PATIENT CARE (continued)

SUBCONTRACTED PROFESSIONALS

Does the practice engage subcontracted or agency professionals to deliver services? ☐ Yes ☐ No

SERVICES PERFORMED BY CONTRACTORS

% OF SERVICES BY CONTRACTORS

Are subcontractors required to carry their own professional liability insurance? ☐ Yes ☐ No ☐ N/A

MINIMUM REQUIRED LIMIT PER SUBCONTRACTOR ($)

PRODUCT SALES & DISPENSING

Does the practice sell, supply, or dispense any products to patients / clients (e.g. skincare, supplements, medical supplies, medications, aftercare products)? ☐ Yes ☐ No

TYPES OF PRODUCTS SOLD / DISPENSED

% OF TOTAL REVENUE FROM PRODUCT SALES

PHARMACY SERVICES

Does the practice operate pharmacy services? ☐ Yes ☐ No

If yes — has a completed pharmacy supplementary application been attached to this submission?
☐ Yes ☐ No ☐ In progress

SERVICES TO MINORS

Does the practice provide services to minors (persons under 18)? ☐ Yes ☐ No

Are signed parental / guardian consent forms collected prior to treatment? ☐ Yes ☐ No ☐ N/A

Are consent forms retained until the minor reaches the age of majority? ☐ Yes ☐ No ☐ N/A

DESCRIBE SERVICES PROVIDED TO MINORS AND APPROXIMATE % OF PATIENT VOLUME

SECTION E — COVERAGE REQUESTED

REQUESTED POLICY EFFECTIVE DATE

CURRENT / PRIOR INSURER (IF ANY)

CURRENT POLICY NUMBER

EXPIRING RETROACTIVE DATE (IF APPLICABLE)

EARLIEST DATE PRACTICE / ENTITY COMMENCED

CURRENT ANNUAL PREMIUM (IF RENEWAL) ($)

LIMIT OF LIABILITY REQUESTED (PER CLAIM, CLAIMS-MADE BASIS)

☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $5,000,000

Any gaps in prior coverage? ☐ Yes ☐ No

DETAILS OF COVERAGE GAPS OR ADDITIONAL NOTES FOR UNDERWRITER

SECTION F — CLAIMS HISTORY

Has the applicant, any listed entity, or any individual provider ever been subject to any claims, suits, demands for compensation, disciplinary proceedings, or regulatory investigations? ☐ Yes ☐ No

If YES — complete the table below for EACH claim or matter. Attach additional sheets if required.

INCIDENT DATE	REPORTED DATE	NATURE OF ALLEGATION	PROVIDER	STATUS	PAID ($)	RESERVED ($)

Are there any known circumstances, incidents, or situations that may give rise to a future claim? ☐ Yes ☐ No

IF YES — DESCRIBE THE CIRCUMSTANCE(S) IN FULL DETAIL

SECTION G — DECLARATIONS & AUTHORIZED SIGNATURE

IMPORTANT NOTICE

The statements made in this application are the basis of any policy issued and shall be deemed incorporated therein. The applicant warrants that the information provided is true, accurate, and complete to the best of their knowledge and that no material facts have been omitted or misrepresented. Material misrepresentation or non-disclosure may render any policy issued voidable at the option of the insurer. Signing this application does not bind the applicant or the insurer to coverage — coverage is only effective upon issuance of a policy and payment of premium.

AUTHORIZED SIGNATORY — NAME (PRINT)

TITLE / POSITION

DATE (MM / DD / YYYY)

SIGNATURE OF AUTHORIZED REPRESENTATIVE