HOLMAN INSURANCE BROKERS LTD.

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Chiropractors Professional Liability Insurance Application

www.holmanins.com
www.chiropractorinsurance.ca

NOTE: THIS APPLICATION IS AN IMPORTANT DOCUMENT AND IS BEING RELIED ON BY THE INSURER TO DETERMINE WHETHER IT WILL PROVIDE YOU WITH COVERAGE. PLEASE ENSURE THAT ALL RESPONSES ARE ACCURATE. THIS DOCUMENT WILL FORM PART OF YOUR POLICY.

"**Applicant**" means the individual practitioner detailed in question 1 overleaf below. This application form must be completed in ink, signed and dated by the **Applicant**. Please attach an updated and relevant resume/CV together with certificates proving all relevant qualifications in respect of this application. All questions must be answered and where appropriate "Not Applicable" or "N/A" specified. The completed application form along with additional information provided will form part of the contract of insurance with the Insurers. All facts material to the proposed insurance must be disclosed fully and truthfully and to the best of the **Applicant**'s knowledge and belief whether or not they are the subject of a specific question herein. In addition to the information contained in the application form including all supporting documentation, if the **Applicant** is aware of any other information which it considers may alter, influence or prejudice the Insurers' appraisal of the risk being proposed, this information must be disclosed in conjunction with this application form.
By signing this application form the **Applicant** is consenting to the use of information, including sensitive personal information. Where personal information relates to third parties, the **Applicant** confirms that it has been given the requisite consent to disclose such information to the Insurers for processing.
If there is insufficient space to complete an answer to any question in this application form, please continue on the continuation space (and additional page) provided, which should then be signed, dated, and attached to this application form.

PROFESSIONAL LIABILITY – "Claims Made"
This insurance is underwritten on a "claims made" basis, which means that if a claim is made against the **Applicant** then the **Applicant** MUST have a current policy in force. Any claims brought against the **Applicant** after the expiry of the policy period (or any specific run-off extension or extended reporting period) will NOT be covered.

A. The policy will NOT cover any claims from incidents which take place before the Retroactive Date, if any, or after the expiration of the policy period (subject to the Extended Reporting Period provision).
B. The policy will provide coverage for claims from incidents which take place on or after the Retroactive Date, if any, but before the beginning of the policy period only if the insured did not know of the incident before the beginning of the policy period.
C. The policy will NOT cover any loss for which a claim is first made after: 1. The expiration of the policy period or its earlier termination date, if any; or 2. The Extended Reporting Period if any and then only in accordance with the terms described in the policy.
D. The policy will only cover claims which are first made: 1. During the policy period; or 2. During an Extended Reporting Period if any and then only in accordance with the terms and conditions described in the Extended Reporting Period Section of the policy.
E. The limits for Defence Costs are included in the limit of liability.

Program Highlights*:

- Comprehensive "Claims Made" Coverage
- Criminal cost defense costs $100,000
- Reimbursement for Coroner inquest $25,000
- Disciplinary Legal Expense reimbursement $25,000
- Disciplinary Legal Expense reimbursement $10,000 for sexual allegations
- Legal expense reimbursement investigation coverage $25,000
- Retro-active Date: Date of initial purchase of continuous claims made coverage (otherwise inception of policy)
- Prior Acts coverage included
- Extended Reporting Period: Automatic 30 days in the event of non-renewal or cancellation (for other than nonpayment of premium) at no charge.
- No additional charge for entity coverage for sole proprietors operating Personal Service Corporations.
- No charge for staff (including secretaries) and students under your supervision
- CGL and Property coverage available
- automatic Retirement option for additional 5 years coverage

* please consult your actual wording as claims are only paid based upon policy issued.

Many Chiropractors provide services outside of the Scope of Practice as a Chiropractor. We are able to meet those needs as part of a Chiropractor Professional liability policy or as a stand-alone policy for those additional professional services only.

Common requests include Holistic counselling, LIfe work coaching, Psych-K, Somato Emotion Release, Emotional Freedom Technique, Homeopathy, Cransioscral Therapy and Total Body modification.

In addition to the above, we have specialized programs for Acupuncture, Osteopathy, Massage, Sports Therapy, Rehabilitation, Traditional Chinese Medicine, Homeopathy, Naturopathy and over 150 other therapies.

Applicant Acknowledgement

Signature _____ Date _____

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WARNING
If the Applicant receives a claim or becomes aware of a circumstance that may give rise to a claim, the Applicant must contact Holman Insurance Brokers Ltd. immediately to ensure that the claim notification provisions under the policy are adhered to. Failure to do so could prejudice the Applicant's ability to claim under the Applicant's insurance policy.

If the Applicant is a new client to Holman Insurance Brokers Ltd. and the Applicant's previous liability policy was not on a "claims made" basis with the same 'retro-active date" to that provided under this insurance application please call Holman Insurance Brokers Ltd. for advice as the Applicant may be exposed to a gap in cover. It is the responsibility of the Applicant to understand the type of insurance they are applying for.

Personal Information of The Applicant (You):

1a.	Full Name of **Applicant**:	First Name	Initial	Last Name

b.	Address:	Street Address	
	City	Province	Postal Code
2a.	Do you operate under a Business Entity or Partnership?	☐ Yes ☐ No	

If yes, Full Name of Business:

Note for Incorporated Business Entity or Partnership Coverage:

This policy being applied for will cover the Business Entity or Partnership if incorporated and up to 2 administrative non-professional staff that do not provide any of the insured services. No additional charge for sole proprietor acting under a company name. There is an additional charge for an Incorporated companies and partnerships. All professionals must apply for individual coverage separately.

2.b.	Telephone Number:	Business #	Cell #
2 c.	Email Address:		Website:

Date of Birth: mm/dd/yyyy

3. Year of Graduation: Name of Degree:

4. Name of Institution from which your degree was obtained:

5. Province in which you are licensed to practice:

6. Total number of course hours taken/years:

7. Date started practice: mm/dd/yyyy

8. Are you now or have you within the past five years, practiced subject to any restriction or limitation imposed upon your license:
If YES, please provide details:

☐ Yes ☐ No

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9.a. Do you provide services or perform activities outside of Canada? ☐ Yes ☐ No

9.b. Do you provide services or perform activities to patients who reside outside of Canada? ☐ Yes ☐ No
If YES, please provide full details (country, licensing requirements, percentage of total practice): _____%

10. Please indicate the number of employees and their respective duties:

Employees	Duties

11 Do you treat professional athletes? ☐ Yes ☐ No

12. Is coverage required for Acupuncture? ☐ Yes ☐ No
Is coverage required for Osteopathy? ☐ Yes ☐ No

13. If coverage is required for Acupuncture or Osteopathy:

a. What percentage of your practice do these services represent? _____%

b. Do you use single usage needles (acupuncture only)? _____

c. Do you belong to any related association? ☐ Yes ☐ No
If YES, please provide the name of the association:

14.a. Do you work with animals? ☐ Yes ☐ No
If **YES**, please advise when this would happen and with what types of animals:

14 b. Are you a student or a candidate for admission to a profession, or an intern or any such other occupation that includes elements of educational tutelage? ☐ Yes ☐ No

Where the **Applicant** is a student or candidate for admission to a profession, or an intern or any such other occupation that includes elements of educational tutelage, it is a condition precedent to the right to be indemnified under this policy that the **Applicant** be under the supervision of a practitioner/instructor qualified within the activities covered and is restricted to performing practice treatments or case work only, and that the **Applicant** advises the recipient of such treatments (or their parent or legal guardian, if the recipient has not attained the age of 16) that they are receiving treatment as part of a training program. The **Applicant** must not offer treatments outside of their capabilities which shall at all times be governed by the phase reached in their training program and their supervising instructor/practitioner's assessment.

If **YES**, please advise name of qualified practitioner or instructor.

Name of qualified practitioner of instructor	Address	Tel #	Email

Please provide qualifications of qualified practitioner or instructor.

14 c. Do you provide sports therapy / rehabilitation / massage therapy or personal fitness instruction to Professional Sports persons and/or dancers? ☐ Yes ☐ No

14 d. Do you teach and/or certify or qualify another to teach others? ☐ Yes ☐ No

Where an applicant is a teacher, teaching is considered certifying and/or qualifying another to teach others. (This should not be confused with instruction of others in participation of an activity.)
Your policy does not extend coverage to the actions of your students. Examples of this would be:
i) a student or graduate injuring another student during practical training;

ii) a student or graduate causes harm to a patient and an allegation is made that the damages were in whole or in part as a result of insufficient or deficient training.
If **YES**, please advise the relationship to whom and how often.
Attach relevant qualifications.

To Whom?	How often?

14 e. Do you require liability coverage for any additional Insured's? Please indicate the relationship, state name and full address. If more space is required, please complete on a separate form. ☐ Yes ☐ No

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It is requested the following entities are to be added to the policy as Additional Insured, but only with respect to the operation of the Named Insured. The certificate applies to the named insured while operating within the scope of your Professional Services.

Name and complete address, including postal code AND email of Additional Insured:			**Interest in the insurance:**
Name: Email :			☐ Corporate Name ☐ Municipality ☐ Clinic ☐ Sponsor ☐ Landlord
Address: (Street)	Province:	Postal Code:	

Name: Email:			☐ Corporate Name ☐ Municipality ☐ Clinic ☐ Sponsor ☐ Landlord
Address: (Street)	Province:	Postal Code:	

15. Do you keep records for at least 7 years for all patients/clients? If **NO**, please explain why **NO**: ☐ Yes ☐ No

16. Do you obtain satisfactory consent in writing from each patient prior to starting treatment? ☐ Yes ☐ No
If **NO,** Please explain why **NO.**

17. Have you ever been disciplined by a licensing body? ☐ Yes ☐ No
If YES, please provide details:

18. Have any negligence claims ever been made against you whether successful or otherwise? ☐ Yes ☐ No

19. Have any claims for dishonesty ever been made against you whether successful or otherwise? ☐ Yes ☐ No

20. Have any complaints or investigations ever been made or undertaken against you? ☐ Yes ☐ No

21. Have you ever had a document relating to the **Applicant's** activities unintentionally destroyed, damaged, lost or mislaid? ☐ Yes ☐ No

22. Has the **Applicant** ever been convicted of a criminal offence, other than a motoring offence, or have any prosecution pending? ☐ Yes ☐ No

23. Have any libel or slander claims, infringement of copyright or breach of confidentiality ever been made against you? ☐ Yes ☐ No

24. Have any sexual harassment and/or abuse claims ever been made against you? ☐ Yes ☐ No

25. Are you aware of any circumstances which may give rise to a potential claim or request for indemnity under this professional liability insurance? ☐ Yes ☐ No

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NOTE: If the answer to any of 18-25 above is **YES**, please provide full details:

26.. Have you ever had a claim made against you whether successful or otherwise in respect of bodily injury, property damage, premises (including tenant's liability), liability, personal injury, advertising liability or medical expenses? If **YES**, please give full details: ☐ Yes ☐ No

27. Do you sell manufacture, distribute or wholesale any products? ☐ Yes ☐ No
If yes, please give full details: _____

28. Do you operate your practice Online or provide E-Services or provide Internet Training or Instructional Videos? ☐ Yes ☐ No

29. Do you currently purchase Liability, Medical Malpractice and/or Professional Liability Insurance? ☐ Yes ☐ No

If YES, please advise the following:

LIMIT:	DEDUCTIBLE	EXPIRY DATE MM/DD/YY	TYPE OF INSURANCE	INSURER	PREMIUM
					$

If you had a "Claims Made" policy and require retro date coverage, please provide evidence of prior insurance policy.

If claims-made, what was the retroactive date of the policy (dd/mm/yyyy): _____

Please provide the date you first purchased continuous Professional Liability Coverage (dd/mm/yyyy): _____

30. Has the Practitioner ever been declined, non-renewed or cancelled by any insurer for Professional Liability insurance? If YES, please attach details: ☐ Yes ☐ No

31. Has any claim been made against the Practitioner in respect of professional services performed? If YES, please attach details. **NOTE: Any prior claims must be referred to the Insurer prior to coverage being placed in effect.** ☐ Yes ☐ No

32. Do you sell manufacture, distribute or wholesale any products? If yes, please give full details. ☐ Yes ☐ No

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Coverage Required

Please select Limit of Liability that you require ▼	Please select Deductible option ▼
☐ $1,000,000 Per Claim, $2,000,000 Aggregate	☐ $NIL Deductible
☐ $1,000,000 Per Claim, $3,000,000 Aggregate	☐ $1,000 Deducible
☐ $2,000,000 Per Claim, $4,000,000 Aggregate	☐ $2,500 Deductible
☐ $3,000,000 Per Claim, $5,000,000 Aggregate	☐ $5,000 Deductible
☐ $5,000,000 Per Claim, $5,000,000 Aggregate Mandatory Ontario limit	☐ $10,000 Deductible

Please advise the date insurance required is to be effective:	MM/DD/YYYY

Protection of the Applicant's Personal Information:
By completing this application and returning it to Holman Insurance Brokers Ltd., the **Applicant** agrees and consents to the collection, use and disclosure of such information, including any personal information, by Holman Insurance Brokers Ltd. For the following purposes:

- Communicating with the **Applicant**
- Assessing the **Applicant**'s application for insurance
- Disclosing information to Insurance Companies
- Negotiating, maintaining or renewing insurance on the **Applicant**'s behalf
- Providing claims assistance and service.
- Advising the **Applicant** of other products or services
- Complying with regulators and legal authorities

For more information about our privacy policies and practices or for a copy of our Privacy Policy please visit our web site www.holmanins.com or contact our Privacy Officer at Holman Insurance Brokers Ltd.

DISCLOSURE OF MATERIAL FACTS

It is essential that every **Applicant** when seeking a quotation, taking out or renewing an insurance policy reveals to the prospective Insurer(s) any material facts or information (including any material circumstances or change in circumstances) which might influence the judgment of Insurer(s) in determining the premium or in determining whether they will accept the risk. Failure to do so may render the contract of insurance voidable from inception at the option of the Insurer(s) and enable them to repudiate liability there under. If you have any doubt as to what constitutes a material fact or circumstance, seek professional advice.

PROGRAM DISCLOSURE

Your coverage will be placed with a program administered by Holman Insurance Brokers Ltd. We have engaged in a marketing process to offer a competitive product on a group basis with insurers be we have not acted as a broker for any individual participant. Should your application not be accepted for whatever reason by the insurer, the information may be used by Holman to seek an alternative insurer if available.

EMAIL AUTHORIZATION

In an effort to bring our policy holders the most cost-effective insurance plan, all of our correspondence is completed electronically, including renewal applications, invoicing and the delivery of the policy documents. the email address supplied by you in this application will be used. We must be notified of any change to your email address. The policy holder agrees that it will hold Holman Insurance Brokers Ltd. harmless with respect to any e-mail changes caused by the policy holder's failure to provide current and valid information for the receipt of documents.

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The Applicant/policy owner further agrees that the policy documents transmitted electronically by Holman Insurance Brokers Ltd. to the electronic address supplied are in lieu of all other forms of communication. The policy Owner accepts that electronic delivery of policy documents is sufficient to meet all reporting requirements of the policy.

DECLARATION
I/we declare that the above statements are true in every respect. I/we hold qualification certificate(s) for the therapy(ies) stated on this application form. I/we have not withheld or misrepresented any material fact. I/we agree that this application will form the basis of the contract between me/us and Holman Insurance Brokers Ltd.

Applicant's Signature **Date**

Print Name

Return completed application and additional materials requested to:

Holman Insurance Brokers Ltd.
1 Valleywood Drive, Suite #100, Markham ON L3R 5L9
Telephone:(905)886-5630

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