Intact Insurance Company

Application for Medical Institutions' Liability Insurance

All questions are to be answered as completely as possible. If a question is not applicable to your situation state N.A. If insufficient space, attach full details.

1. Name of Applicant:
   Mailing Address:
   (Number) (Street) (City) (Prov.) (Postal Code)
2. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation
   ☐ Other (give details):
3. Location of all Clinics, Homes or Medical Institutions operated by Applicant:

Address	Operated as	Construction	Age

4. Indicate type of institution and rating information:
   - ☐ Convalescent or Nursing Home – number of beds
   - ☐ Home for the Aged – number of beds
   - ☐ Chronic Care Hospital – area in sq. metres
   - ☐ Mental Health Care – area in sq. metres
   - ☐ Medical Laboratories – revenue
   - ☐ Sanitarium – area in sq. metres
     – number of beds
   - ☐ Medical Clinic – area in sq. metres
   - ☐ Public Health Clinic – area in sq. metres
   - ☐ Specialty Clinic – area in sq. metres
   - ☐ Sonography Clinic – number of machines
   - ☐ X-ray Clinic – number of machines
   - ☐ Other – give details:

5. State number of employed:

Counsellors/Social Workers	Psychologists
Dentists	Registered Nurses
Kinesiologists	Registered Practical Nurses
Laboratory Technicians	Sonographers
Occupational Therapists	Surgeons
Pharmacists	X-Ray Technicians
Physicians	Other Professionals
Physiotherapists	*(state number and profession)*

State number of medical staff, not employed, but having use of Applicant's facilities:

Physicians Surgeons Other (state number and profession)

Note: This Professional Liability Insurance excludes the services of Physicians and Surgeons when they carry out or fail to carry out an act in the practice of their profession.

6. Does the Applicant, or his/her employees, have Professional Liability Insurance through a Professional Association? ☐ Yes ☐ No

If yes, state:

Professional Association	Number	Limits		Primary or Excess
		Per claim	Aggregate	

7. Does Applicant engage in or specialize in surgery? ☐ Yes ☐ No

If yes, give details:

8. What classes of patients are treated? State approximate percentage for each:

Medical: % Surgical: % Mental: % Drug Addicts: % Alcoholics: %
Other, give details: %

9. State number of outpatients handled during past year:

10. Is treatment in this institution paid by: ☐ Government ☐ Other, give details:

11. Does Applicant own or operate a helipad? ☐ Yes ☐ No

If yes, state location and size:

12. If X-Ray machines are used, are they for therapeutic or treatment purposes (as distinguished from diagnostic use)? ☐ Yes ☐ No

If yes, give details:

13. Does the Applicant employ either hypnosis or shock therapy in the rendering of professional services? ☐ Yes ☐ No

If yes, comment on the extent of use of such practices:

14. Has the Applicant entered into any written contracts for the provision of professional care service or treatment to any organization or institution (such as, but not limited to schools, colleges, penal institutions, etc)? ☐ Yes ☐ No

If yes, explain fully and submit a copy of the contract:

15. Is Applicant affiliated with: ☐ A training school for nurses ☐ A university or college

If yes, give details:

16. a) Does Applicant perform medical testing? ☐ Yes ☐ No

If yes, give details:

b) Does Applicant test for AIDS? ☐ Yes ☐ No

If yes, state % of revenue.

17. If overnight care is provided, does Applicant have written evacuation procedures? ☐ Yes ☐ No

If yes, how often are these practiced?

18. Does Applicant offer a Needle Exchange Program? ☐ Yes ☐ No

19. Give particulars of all professional liability insurance held by the Applicant for the past five years:

Type of Policy		Policy Number	Insurer	Policy Limit	Policy Period
Claims Made	Occurrence				
*					
*					
*					
*					

If the policy is subject to a Retroactive Date, give details:

20. Has any claim or suit alleging malpractice, a negligent act, error or omission, or breach of duty been brought against the Applicant within the past five years? ☐ Yes ☐ No

If yes, give details:

21. Has the Applicant any knowledge of any circumstance which could result in claim or suit being brought against the Applicant? ☐ Yes ☐ No

If yes, give details:

22. Limits of Insurance desired:

Commercial General Liability	$	each occurrence	$	aggregate
Professional Liability	$	each claim	$	aggregate

I/We declare that during the last five years no insurer has cancelled, declined or refused to issue me/us any form of liability insurance and that this application discloses the hazards known to exist at the date of this application.

I/We declare that the statements made herein are in every respect true and correct and hereby apply for a contract of insurance to be based upon the truth of the said statements.

Signed by: _____ Date: _____

Position: _____

Broker: _____

Signing of this form does not bind the Applicant to complete the insurance.