



PLEASE READ THESE GUIDANCE NOTES BEFORE COMPLETING THE PROPOSAL FORM, WHERE FURTHER INFORMATION IS REQUIRED PLEASE REFER TO YOUR BROKER / INSURANCE AGENT.

PLEASE NOTE This Proposal Form is for a CLAIMS MADE policy. A CLAIMS MADE policy only responds to "claims" made against the Insured and notified to Underwriters during the period of insurance.

- This Proposal Form must be typed, or completed in ink and signed and dated by the Proposer. Please answer every question fully, and state "NIL" or "NONE" as applicable. Incomplete answers may not be accepted and can delay quotation,
- Please complete separate Proposal Forms for each Partner to be included in the quotation and attach a list of all Partners.
- Please submit any additional information you feel may be of assistance to Underwriters, such as Brochures etc.
- Should there be insufficient room in the Proposal Form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.
- It is the duty if the Proposer to disclose all material facts to Underwriters. Where this is omitted, the Underwriters may avoid their obligations under the Policy.

For the purposes of the Proposal and for all purposes relating to any policy issued pursuant to this Proposal, a 'material fact' shall be deemed to be one that would be likely to influence an Underwriter's judgement and acceptance of your Proposal.

- Upon acceptance of the Underwriters' terms and conditions and payment of the premium all information provided by the Proposer together with the guidance notes will be deemed to be incorporated in the contract between Underwriters and the Insured.

Copies of the Proposal Forms should be retained for your own records.

COMPLEMENTARY MEDICAL PRACTITIONERS	
Calgary Office 100, 1400 1 ST Street SW, Calgary, A Tel: (403) 263-4666 Toll Free: 1-888-263-5146 Fax: (403) 237-9976	Montreal Office 300, Rue St. Sacrement, Suite 307 (514)844-2541 Toll Free 1-888-840-2541 Fax (514)843-5926
Simcoe Office 2 Norfolk Street South Simcoe, Ont N3Y 2V9 Tel: (519)428-1688 Toll Free 1-866-401-3858 Fax (519)428-6307	Toronto Office 901 Yonge Street, Suite 106 Toronto, Ont M4W3V8 Tel: (416)925-2793 Toll Free 1-888-745-5502 Fax (416)925-7260

1. Full Name of the Insured:

Date of birth:

2. Trading name (if different from the above):

3. Have you ever engaged in a similar activity under a different name?

YES NO

If 'YES' please give full details:

4. i) Address:

 Postal Code: _____ Country : _____
 Telephone Number : _____
 Facsimile Number : _____

ii) Practice / Trading address/es (if different from above):

 Postal Code: _____ Country: _____
 Telephone Number: _____
 Facsimile Number: _____

If cover is required for more than one location, please attach a list of all addresses.

SIGNING OF THIS PROPOSAL DOES NOT BIND THE PROPOSER OR UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE

5. i) **WHAT IS YOUR TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS?**
 (If new business please state estimated income for the forthcoming 12 months).
THIS QUESTION MUST BE ANSWERED.

ii) Total number of Treatments/Sessions/Consultations?

6. i) In what branch or branches of complementary medicine are you qualified and, if applicable, licensed to practise?

- | | | | |
|----------------------|--------------------------|-----------------------|--------------------------|
| Acupuncture | <input type="checkbox"/> | Iridology | <input type="checkbox"/> |
| Acupressure | <input type="checkbox"/> | Kinesiology | <input type="checkbox"/> |
| Alexander Technique | <input type="checkbox"/> | Light Touch Therapy | <input type="checkbox"/> |
| Aromatherapy | <input type="checkbox"/> | Massage | <input type="checkbox"/> |
| Ayurveda | <input type="checkbox"/> | Moxibustion | <input type="checkbox"/> |
| Bach Remedies | <input type="checkbox"/> | Music Therapy | <input type="checkbox"/> |
| Bates Method | <input type="checkbox"/> | Multi Vitamin Therapy | <input type="checkbox"/> |
| Biochemics | <input type="checkbox"/> | Naturopathy | <input type="checkbox"/> |
| Chiropractic | <input type="checkbox"/> | Nutrition Therapy | <input type="checkbox"/> |
| Colonic Irrigation | <input type="checkbox"/> | Osteopathy | <input type="checkbox"/> |
| Colour Therapy | <input type="checkbox"/> | Polarity Therapy | <input type="checkbox"/> |
| Counselling | <input type="checkbox"/> | Psychotherapy | <input type="checkbox"/> |
| Crystal Therapy | <input type="checkbox"/> | Radionics | <input type="checkbox"/> |
| Craniosacral Therapy | <input type="checkbox"/> | Reflexology | <input type="checkbox"/> |
| Healing/Reiki | <input type="checkbox"/> | Rolfing | <input type="checkbox"/> |
| Herbalism | <input type="checkbox"/> | Shiatsu | <input type="checkbox"/> |
| Homeopathy | <input type="checkbox"/> | Yoga | <input type="checkbox"/> |
| Hypnosis | <input type="checkbox"/> | | |

Other (please specify):

ii) Please provide on a separate piece of paper, full details of all qualifications and courses that you have undertaken on the above branches of Medicine.

7. Please give full details of what patient records are kept where and how they are stored and for how long they are retained:

Please note it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

8. Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed:

EMPLOYED SELF-

	EMPLOYED	
The Proposer's Private Practice Clinics		
Private Non-Surgical Nursing Homes and Hospices		
Patients' Homes		
Other (please specify)		
Total:		

If you are an employee, please state the name of the company (or other entity) for whom you work:

9. Do you own (wholly or in part), operate or administer any hospital, nursing home or any other medical establishment?

YES NO

IF THE ANSWER IS 'YES' AN ADDITIONAL PROPOSAL FORM WILL HAVE TO BE COMPLETED BEFORE QUOTATIONS CAN BE GIVEN.

10. i) Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e. Hepatitis, H.I.V. etc, or other impediment which may affect the performance of his/her professional duties or place patients/clients at risk?

YES NO

If 'YES' procedures are in place?

ii) Has the Proposer or any employee involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries?

YES NO

If 'YES' please give full details:

11. i) Are you a member of any professional organisation, or registered with any self regulating body?

YES NO

If 'YES' please state which and period of membership/registration:

ii) Has membership or registration with such organisation/body ever been suspended, withdrawn, amended or declined or had conditions attached?

12. If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance? YES NO
 ii) The Insurance period:

13. Have you ever been Insured for Medical Professional Liability? YES NO
 iii) The limits of liability provided:

If 'YES' please state:

i) The name of the Underwriter/s:

iv) Has any application for this type of Insurance cover ever been:

- a) declined? YES NO
- b) cancelled? YES NO
- c) required special terms? YES NO

If 'YES' please give full details:

14. Please complete for each member of staff to be covered:

Full time/Part Time	Branch of Medicine	Qualification	Date Qualified

PREVIOUS CLAIMS HISTORY

15. i) List all claims made against the Proposer during the last 10 years. **IF NONE, PLEASE STATE "NONE"**:

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the allegations and details of Claimant

ii) List all circumstances/complaints, which may give rise to a claim being made against the Proposer:

IF NONE, PLEASE STATE "NONE":

Date of Circumstance/ Complaint	Details including nature of the Complaint and details of Complainant

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16. i) Have all of the above in question 15 been notified to your previous Underwriters YES NO
- ii) Have all of the above been accepted by your previous Underwriters? YES NO

17. Please indicate which limit(s) of indemnity you require quotations for:

- ¼ million ½ million 1 million 2 million Other (please specify)

I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as practicable. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.

NAME OF PROPOSER

(IN BLOCK CAPITALS)

SIGNATURE

Dated

PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE APPROPRIATE QUESTION NUMBER.