



COMPLETION OF THIS FORM INDICATES YOUR CONSENT FOR PROCESSING YOUR PERSONAL INFORMATION. PLEASE REFER TO PAGE 5 FOR DETAILS ON OUR PRIVACY POLICY.



## Professional and General Liability Insurance Application for Individual Regulated & Allied Healthcare Personnel

Please read and complete the application in its entirety. Blanks &/or dashes are not acceptable and will delay consideration of this application. Answer all questions, if the question does not apply, indicate "N/A" in the space provided.

### SECTION 1 – GENERAL INFORMATION

1. Name (Please print):												
Trading Name if different from the above:												
2. Address:				Is this your residence?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
City/Town:			Province:		Postal Code:							
Phone No.:			E-Mail:									
3. Practice Address if different from the above:												
City/Town:			Province:		Postal Code:							
Phone No.:			E-Mail:									
4. Are you a current policy holder or a new applicant?					<input type="checkbox"/> Existing Holder <input type="checkbox"/> New Applicant							
5. Describe your employment status:					<input type="checkbox"/> self-employed/independent contractor <input type="checkbox"/> employed practitioner <input type="checkbox"/> contract employee							
6. If you are an employee, provide the name of your employer:												
7. If you are self-employed, what is the legal structure of your business:					<input type="checkbox"/> sole proprietorship <input type="checkbox"/> corporation <input type="checkbox"/> professional corporation (Ontario only) <input type="checkbox"/> partnership							
8. Do you own or operate a healthcare entity?					<input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, the name of the entity is:												
Contact Name:			Telephone No.:									
Email Address:			Year Established:									
9. Please state your gross annual revenue excluding revenue from the sale of goods in respect of the following years (in CAD):					Last Year:		\$		This year:		\$	

If you own or operate a healthcare establishment, you must complete SWG's Healthcare Establishment Application before quotations can be given.

### SECTION 2 – PROFESSIONAL PRACTICE

#### PART A – REGULATED HEALTHCARE PROFESSIONALS

1. In what capacity are you licensed to practice?

Audiologist	<input type="checkbox"/>	Medical Radiation Technologist	<input type="checkbox"/>	Podiatrist	<input type="checkbox"/>
Chiropodist	<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>	Psychologist	<input type="checkbox"/>
Dental Hygienist	<input type="checkbox"/>	Optician	<input type="checkbox"/>	Psychotherapist	<input type="checkbox"/>
Dental Technologist	<input type="checkbox"/>	Optometrist	<input type="checkbox"/>	Registered Nurse	<input type="checkbox"/>

Denturist	<input type="checkbox"/>	Pharmacist	<input type="checkbox"/>	Registered Practice Nurse	<input type="checkbox"/>
Dietitian	<input type="checkbox"/>	Pharmacy Technician	<input type="checkbox"/>	Respiratory Therapist	<input type="checkbox"/>
Kinesiologist	<input type="checkbox"/>	Nurse Practitioner	<input type="checkbox"/>	Speech-language Pathologist	<input type="checkbox"/>
Medical Laboratory Technologist	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>		

2. Number of years in practice: \_\_\_\_\_

3. Are you a member of an applicable professional association?  Yes  No  N/A  
 If yes, please list membership affiliations: \_\_\_\_\_

4. Are you accredited and/or certified?  Yes  No  N/A  
 If yes, please list accreditations and/or certifications: \_\_\_\_\_

**PART B – Allied Healthcare Personnel**

1. In what capacity are you licensed to practice?

Alcohol & Drug Counsellor	<input type="checkbox"/>	Medical Technician	<input type="checkbox"/>	Recreation Therapist	<input type="checkbox"/>
Ambulance Attendant (non-paramedic)	<input type="checkbox"/>	Mental Health Counsellor	<input type="checkbox"/>	Rehabilitation Counsellor or Therapist	<input type="checkbox"/>
Attendant	<input type="checkbox"/>	Music Therapist	<input type="checkbox"/>	Respiratory Therapy Technician	<input type="checkbox"/>
Care Aide	<input type="checkbox"/>	Occupational Therapy Assistant	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
Dental Assistant	<input type="checkbox"/>	Orthopedic Assistant	<input type="checkbox"/>	Sports Medicine Instructor	<input type="checkbox"/>
Dialysis Technician	<input type="checkbox"/>	Orthoptist	<input type="checkbox"/>	Surgical Technician	<input type="checkbox"/>
Dietary (Nutritionist)	<input type="checkbox"/>	Personal Support Worker	<input type="checkbox"/>	Wellness Counsellor	<input type="checkbox"/>
Consultant	<input type="checkbox"/>	Pharmacy Technician/Assistant	<input type="checkbox"/>	Other (Please specify): _____	<input type="checkbox"/>
Fitness Professional	<input type="checkbox"/>	Phlebotomist	<input type="checkbox"/>		
Healthcare Counsellor	<input type="checkbox"/>	Physiotherapy Aide/Assistant	<input type="checkbox"/>		
Hearing Aid Fitter	<input type="checkbox"/>	Podiatry Assistant	<input type="checkbox"/>		
Laboratory Technician	<input type="checkbox"/>				

2. Number of years in practice: \_\_\_\_\_

3. Are you a member of an applicable professional association?  Yes  No  N/A  
 If yes, please list membership affiliations: \_\_\_\_\_

4. Are you accredited and/or certified?  Yes  No  N/A  
 If yes, please list accreditations and/or certifications: \_\_\_\_\_

**SECTION 3 – INSURANCE COVERAGE REQUIRED**

1. Please select the type(s) of coverage you wish to purchase and the limit desired for each coverage:

Type of Coverage		Limit \$1 Million	Limit \$2 Million	Limit \$5 Million
Professional Medical Malpractice (Claims Made)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Commercial General Liability (Occurrence)	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**SECTION 4 – GENERAL LIABILITY – THIS POLICY IS ON AN OCCURRENCE BASIS**

1. Complete a brief description of your premises in the table below:

Name of Building	Location	Year Built	Size (sq.ft.)	# of Storeys

2. Do you require coverage on any business/entity that you own or control?  Yes  No  N/A

3. Please list any premises' function or facilities that you sub-contract (e.g., cleaning, waste disposal, etc.): \_\_\_\_\_

4. Do you require sub-contractors to carry adequate insurance and name your establishment as an additional insured to their insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. Do the premises comply with current fire protection and prevention requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6. Are you aware of what to do in the event of fire or other emergency?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7. Do the premises have an emergency back-up system (e.g., for lighting, fire protection)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8. Are facilities for safe collection, storage and disposal of bio-medical waste provided in accordance with current guidelines/legislation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>SECTION 5 – – PROFESSIONAL LIABILITY SECTION – THIS POLICY SECTION IS ON A CLAIMS MADE BASIS</b>	
1. Is informed consent obtained prior to all procedures/tests etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. Are there written procedures for you to handle medical emergencies (e.g., anaphylaxis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3. Are you certified in Basic Life Support?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. Infection Prevention and Control:	
Are you in compliance with all regulatory workplace health & safety requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you follow the current guidance for infection prevention & control issued by the Public Health Agency of Canada; Ministry of Health or any regional; provincial / territorial public health authorities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes - when was the guide last updated?	
Do you have a written plan for managing an outbreak of a communicable disease in your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Complete the following questions only if answers to the above questions are "No".</b>	
Is there a process of managing patient / customer with symptoms of communicable disease to prevent transmission to others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you follow the environmental cleaning protocol in the personal services environment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ensure that staff follows the hand hygiene protocols?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is immunization against flu required to all staff in your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain.	
Are all equipment clean and disinfected / sterilized as per current provincial best practices guidelines before reuse with another patient / customer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use single use towels or other protective covers on tables / beds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you dispose all waste including single use device in accordance with regulatory requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are all staff able to demonstrate adequate knowledge of general principles of infection control prevention including the common communicable disease risks for staff in the personal services setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are the appropriate personal protective equipment (PPE) readily available and easily accessible to all staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have protocols in place to obtain and maintain adequate quantities of equipment, products, materials needed for the Infection prevention and control to prevent transmission of the disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you trained on all equipment you use in your practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6. Does all equipment utilized in your practice undergo periodic inspection, testing, and preventive maintenance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7. Are records of inspection, maintenance, testing and calibration of equipment kept?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8. Are clinical records retained for a least ten (10) years from the date of the patient/client's last visit, and in the case of minors, for at least ten (10) years after that minor attains majority?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
9. Are measures in place for the protection of patient/client health information in compliance with relevant privacy legislation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
10. Do you product or supply products?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
11. Do you fit or alter products such as wheelchairs and like devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

**SECTION 6 – CLAIMS AND INSURANCE HISTORY**

**A. Claims**

1. Have any negligence claims ever been made against you whether successful or otherwise?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
2. Have any claims for dishonesty ever been made against you whether successful or otherwise?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
3. Do you have a record of disciplinary action with your professional association, including revocation or suspension of your license by the governing body of your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
4. Have you ever been convicted of violating any law, except a minor traffic offence, as a result of your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
5. Have any sexual harassment and/or abuse claims ever been made against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
6. Please list all claims and incidents that may result in a claim, prior to the effective date of this proposed policy, which would have given rise to a claim, arising from your professional activities in the past year. If none, state "none":													
<table border="1"> <thead> <tr> <th>Year of Incident</th> <th>Nature of Injuries</th> <th>Injured Party</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Year of Incident	Nature of Injuries	Injured Party										
Year of Incident	Nature of Injuries	Injured Party											

**B. Insurance History**

1. Have you ever been declined, cancelled or non-renewed by an insurance for Professional Liability Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been cancelled for non-payment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has prior coverage been a Claims Made Basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If claims made, most recent retroactive date (mm/dd/yyyy):**

Previous Insurer	Policy No	Liability Limits	Premium	Expiry Date (mm/dd/yyyy)

**NOTICE CONCERNING PERSONAL INFORMATION**

By soliciting insurance from South Western Insurance Group Limited, you agree and provide consent that your personal information, including that previously collected, will be collected, processed, used, communicated, transferred and retained for the following purposes:

- the communication with underwriters;
- the evaluation of claims;
- the analysis of business results;
- the underwriting of policies;
- the detection and prevention of fraud;
- purposes required or authorized by law.

• In accordance with SWG's privacy policy available at the bottom of this application and as per our website: <https://swgins.com/page/privacy.html>

You can exercise your right to access your personal information in our possession, to have it rectified or to withdraw your consent by contacting us at [PrivacyOfficer@swgins.com](mailto:PrivacyOfficer@swgins.com). Should you exercise your right to withdraw your consent to the communication or use of the information collected required to provide certain products or services, this would prevent South Western Insurance Group from being able to provide such products or services. Further information about South Western Insurance Group Limited personal information protection policy may be obtained by contacting our privacy officer at 416-620-6604.

**WARRANTY STATEMENT**

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. In the event that there is any material change in the answers given to the questions contained in this application prior to the inception of the policy, the applicant must notify the underwriters in writing and the underwriters may revoke, or effect changes to, the quotation provided. Signing of the proposal does not bind the undersigned to complete the insurance but it is agreed that this form, and any additional information/document provided in support thereof by the client and/or broker, shall be the basis of the contract should a policy be issued.

**NEW BRUNSWICK RESIDENTS ONLY:**

I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language.

**SIGNATURE**

Signature:		Date (mm/dd/yyyy):	
	(Authorized Representative)		
Name (please print):		Title/Position:	



## Privacy Policy

South Western Insurance Group Limited is committed to protecting the privacy and the confidentiality of our brokers and their Insured's personal information. In order to comply with privacy legislation, we have developed this Privacy Policy. Any personally identifiable information about an Insured is considered personal information and will be treated in accordance with this Privacy Policy.

### IDENTIFIED PURPOSES

South Western Group only collects, uses and discloses Personal Information for the following purposes:

- Offering and providing insurance and related products and services;
- Verifying the identity and the accuracy of personal information with government agencies, industry associations, or other Insurers;
- Analyzing, assessing and underwriting risks on a prudent basis;
- Investigating and paying claims;
- Detecting and preventing fraud or other illegal activities;
- Compiling statistics;
- Complying with the laws or the requests of law enforcement agencies or regulators.

In this Privacy Policy, the above list of Identified Purposes will be referred to as the 'Identified Purposes'.

### THIRD PARTY DISCLOSURE

South Western Insurance Group may share information about you with third party companies, permitted by law. Such disclosures may include those that South Western feels are required to provide customer service, prevent fraud, perform research or comply with the law. Recipients may include South Western's family of insurance service companies, claims representatives, service providers, consumer reporting agencies, insurance agents and brokers, law enforcement, courts and government agencies. These parties may disclose the information to others as permitted by law.

### PRIVILEGE & CONFIDENTIALITY NOTICE – Electronic Messages

Electronic mail or faxes and any files transmitted with them are confidential and may be privileged and are intended solely for the use of the individual or entity to whom they are addressed. If you have received this e-mail in error, please notify the sender immediately.

### CONSENT

South Western Group relies on the following actions by our Brokers and Companies as indication of their consent from an Insured to our existing and future Personal Information practices:

- The Broker has voluntarily requested personal information from an Insured for the purpose of acquiring an insurance contract or related service or product;
- The Broker has the Insured's express consent or acknowledgement contained within a written, verbal or electronic application process;
- The Insured's consent solicited by our Companies or our Brokers is for a specified purpose;
- The Broker must provide the Insured with a copy of their privacy policy and must inform South Western Group of any withdrawal of this consent by an Insured;
- The Broker may obtain the Insured's consent through the Insured's authorized representative such as a legal guardian, agent or holder of a power of attorney.

If an Insured refuses to provide the Broker with certain Personal Information or withdraws their consent South Western Group may be unable to provide insurance coverage.

### LIMITING COLLECTION AND RETENTION OF PERSONAL INFORMATION

South Western Insurance Group will only collect, use or disclose personal information that is necessary for the Identified Purposes or as required by law. We will retain personal information only as long as necessary for the fulfillment of the Identified Purposes. South Western may store certain data in jurisdictions outside of Canada and may share information with third party companies that are located outside of Canada.

## ACCURACY

South Western Group requests our brokers to maintain the Insured's Personal Information as accurate, complete, and up-to-date as is necessary for the Identified Purposes.

## SAFEGUARDS

South Western Group will protect the Insured's Personal Information by security safeguards appropriate to the sensitivity of the information. Safeguards will vary depending on the sensitivity, format, location and storage of the Personal Information.

## ACCOUNTABILITY, OPENNESS AND ACCESS

South Western Group is responsible for all Personal Information under its control and has designated a Privacy Officer who is accountable to Senior Management for South Western's compliance with the Privacy Policy.

You may contact our Privacy Officer at [PrivacyOfficer@swgins.com](mailto:PrivacyOfficer@swgins.com).

## CHALLENGING COMPLIANCE

If any Broker is not satisfied with South Western's response to a privacy related inquiry or complaint, they may contact the Office of the Privacy Commissioner of Canada during business hours at [1-800-282-1376](tel:1-800-282-1376) or at [www.privcom.gc.ca](http://www.privcom.gc.ca).

**Please refer to the updated comprehensive version of privacy policy on our website: <https://swgins.com/page/privacy.html>**