

MEDICAL MALPRACTICE INSURANCE APPLICATION FOR TCM PRACTITIONERS

IF INSUFFICIENT SPACE FOR REPLY, PLEASE ATTACH ANSWER SEPARATELY

1. Name of Applicant: _____

2. Address of Applicant: _____

_____ Postal Code _____

3. Phone Number: _____

4. Fax Number: _____

5. Email Address: _____

6. Website Address: _____

7. Name and Address of Employer if applicable:

8. Are you a member of TCM PAC in good standing? Yes _____ No _____

9. Describe your operations and/or practices:

(Please attach your brochure if available)

10. Number of years experience as a TCM Practitioner:

11. Have you ever been subject to disciplinary action by any professional licensing body? *(If yes, please provide details)*

12. Have you ever been the subject of any criminal action as a result of your profession? *(If yes, please provide details)*

13. Were you previously insured for Medical Malpractice / Professional Liability before joining this program? Yes _____ No _____

If yes, please attach a copy of the covering page of the most recent policy **showing the retroactive date, policy period, and name of Company and Policy number** or advise the following:

ü *List names of previous Insurance Companies with policy Numbers):*

ü *Number of years insured there?* _____

ü *When did the coverage expire?* _____

14. Have you ever had similar Insurance declined, cancelled or refused renewal?

15. Have you ever had a Medical Malpractice / Professional liability claim or commercial liability claim filed against you at any time during your professional career? *(If yes, please provide details)*

16. Have you any knowledge or information of any negligent act, any error, or any omission or breach of duty, which might give rise to a claim being brought against you, either currently, or some time in the future?
(If yes, please provide details)

17. Please advise your gross revenues from last year: \$ _____

What is your expected revenue for the current year: \$ _____

Please contact us directly for Commercial Liability & Property Insurance.

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURER, IT IS AGREED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

The undersigned Applicant for this insurance declares that, to the best of his/her knowledge and belief, the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned further agrees that if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy.

Signature of Applicant & Title

Date

Important Reminder: The insurance provided under this program applies to each member on an individual and separate basis. A separate application is required for each individual member.

All Medical Malpractice /Professional Liability claim circumstances must be made during the policy period when the policy is in effect.

**INSURANCE COVERAGE PROVIDED BY SOUTH WESTERN INSURANCE GROUP LTD AND ARRANGED BY
YOUR ASSOCIATION AND ZAREENA KHAN @ GUTHRIE INSURANCE BROKERS
PROCEDURE IN APPLYING FOR INSURANCE COVERAGE**

After completing the attach application, please follow the next steps in applying for the coverages:

State Coverage Selected with required limit of Insurance and premium plus sales tax:

Medical Malpractice/ Professional Liability Insurance:

q Limit of Liability: \$1,000,000 per Loss and \$2,000,000 per policy year

Annual Premium is \$350 annually plus applicable sales tax.

See below for prorated amount if purchased from June 20, 2005 to June 20, 2006.

Selection: \$

Add Tax: (Ontario 8%, Quebec 9%, Maritimes 15%): \$

Total: \$

Please make our cheque Payable to Guthrie Insurance Brokers

Note Commercial General Liability and Commercial Property coverages are not available via the program – please call us to arrange coverage separately, if required,

Premium Breakdown for members joining during the policy period:

If coverages is purchased between these period the cost will is as shown on your right:	Prorated Premium to June 20, 2006	Annual Medical Malpractice/Professional Liability Premium
Between June 20 to September 20	Full Premium	\$350 plus tax
Between September 21 to December 22	75% of full premium	\$263 plus Tax
Between December 23 to March 23	50% of full premium	\$175 plus tax
Between March 24 to June 20	25% of full premium	\$86 plus tax

Please send your completed and signed application with payment for coverage selected to:

Zareena Khan FCIP CRM, Risk Manager & Account Manager
Guthrie Insurance Brokers, 505 Consumers Road, Suite 308
Toronto, Ontario M2J 4V8

Direct Dial: 416 691 0890, General: 416 487 5200 Ext. 311 Or 316, General Fax: 416 487 4614

Email address: zareena.khan@rogers.com