



APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR MULTIDISCIPLINE CLINICS

Name of Applicant: _____

Clinic/Business Name: _____

Address: _____

City: _____ Prov./Terr.: _____ Postal Code: _____

Telephone: _____

Email: _____

Clinic/Business Location (if different from above):

Address: _____

City: _____ Prov./Terr.: _____ Postal Code: _____

Clinic/Business Details:

1. Has applicant operated under a different name in the past? Yes No
If yes, please provide details.

2. Does the Clinic/Business provide services or perform activities outside of Canada? Yes No

3. Indicate the number of professionals providing services for or on behalf of the Clinic/Business:
Professional _____

4. Complete the following for each professional providing services for or on behalf of the Clinic/Business:

| Name | Duties | Professional Designation |
|------|--------|--------------------------|
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5. Coverage is provided for **the Clinic/Business**. Each professional providing services for or on behalf of the clinic / business must carry their own individual professional liability insurance with a minimum of \$5,000,000 limits Yes No

I understand and confirm:

6. Is the Clinic/Business involved in any process of manufacturing, construction design, testing or servicing of any equipment? Yes No
If yes, please provide details.
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7. Does the Clinic/Business issue guarantees and/or warranties to customers? Yes No
If yes, attach full details and copy of applicant's form of guarantee or warranty.
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Applicant Details:

8. Are you a member in good standing with the Canadian Association of Occupational Therapists? Yes No
Membership Number:
-

9. Applicant is: Individual Partnership Corporation
 Other (Provide Details) _____
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10. Has any application for similar insurance ever been denied or cancelled? Yes No
If yes, please provide details.
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11. Have you/your business ever sustained a professional liability loss or has such a claim been made against you/your business? Yes No
If yes, please provide details.
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12. Do you have any knowledge of any act/incident, which might give rise to a claim under this policy, or do you anticipate any claims being brought against you/your business? Yes No
If yes, please provide details.
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Multidiscipline Clinic Professional Liability Insurance (Policy is on a claims-made basis)

\$6,000,000 per claim
\$6,000,000 per policy year

Rates

| Disciplines | Rates Per Professional | No. of Professionals | Total Premium |
|---|---|----------------------|---------------|
| Occupational Therapist | | | |
| <ul style="list-style-type: none"> • Full Time (Insured through CAOT program) • Not insured through CAOT program • Part time | \$129 \$184 \$88 | | |
| Acupuncturist / Traditional Chinese Medicine | \$594 | | |
| Aesthetician | \$347 | | |
| Audiologists/Speech Language Pathologist | \$183 | | |
| Behaviour Consultant | \$372 | | |
| Chiropodist | Referral Required | | |
| Counsellor/Social Worker | \$184 | | |
| Dietician | \$217 | | |
| Ergonomist | \$233-Referral | | |
| Exercise Therapist | \$193 | | |
| Kinesiologist | \$184 | | |
| Massage Therapist | \$184 | | |
| Osteopath | Referral Required | | |
| Physiotherapist | | | |
| <ul style="list-style-type: none"> • Full Time • Part Time | \$184 \$134 | | |
| Pedorthist | Referral Required | | |
| Personal Trainer | \$165 | | |
| Prosthetics and Orthopedic Appliance Manufacturing | Referral Required | | |
| Psychologist | \$495 | | |
| Relationship Development Intervention Consultants | \$471 | | |
| Sonographer/X-ray Technician | \$124 | | |
| Vocational Evaluator | \$322-Referral | | |
| Yoga/ Pilates Instructor | \$165 | | |
| Disciplines Excluded: | Chiropractor, Physician, Naturopath | | |
| | | | |
| | Total Premium from all disciplines: Plus applicable sales Tax: | | |

Declarations and Warranty

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

If you are unsure of your coverage requirements please contact BMS Group. A licensed insurance broker will be available to answer your questions during regular business hours.

Signed by:

Position:

Date:

Signing of this form does not bind the Applicant or company to complete the insurance but it is agreed that this form shall be the basis of the contract should a policy be issued.

The insurance premium is fully retained and not refundable.

Payment Information

The following provinces are subject to provincial sales tax:

Ontario residents add 8% sales tax
Québec residents add 9% sales tax
Manitoba residents add 7% sales tax
Newfoundland residents add 15% sales tax
Saskatchewan residents add 6% sales tax

Sub-total \$

Tax \$

Total Enclosed \$

All other provinces are exempt.
GST is not applicable to insurance premiums.

All cheques payable to BMS Canada Risk Services Ltd, or complete credit card authorization below.

Authorization for Credit Card Charge

VISA, AMEX or M/C Account No:

Expiry Date:

Cardholder Name:

Signature:

BMS Canada Risk Services Ltd. (BMS Group)

825 Exhibition Way, Suite 209

Ottawa, ON

K1S 5J3

Toll Free: 1-855-318-6024

Fax: 613-701-4234

Email: caot.insurance@bmsgroup.com