



**HENRY EQUESTRIAN**  
 INSURANCE BROKERS LTD.  
 P.O. Box 578, 28 Victoria Street  
 Aurora, Ontario L4G 3L6

**COMPLEMENTARY MEDICAL PRACTITIONERS  
 APPLICATION**

Office: (905) 727-1144  
 Toll-Free: 1-800-363-36-HEP  
 or 1-800-565-4321  
 Fax: 905-727-4986  
 Email: hep@hep.ca

1. Name of the Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

2. Operating Name: \_\_\_\_\_

3. Have you ever engaged in a similar activity under a different name? Yes  No

If "Yes", please give full details: \_\_\_\_\_

4. i) Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

Practic/Operation Address (if different from above: \_\_\_\_\_

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

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) \_\_\_\_\_

ii) What percentage of your total gross annual income will be earned: in the U.S.A. \_\_\_\_\_%, other foreign \_\_\_\_\_%

iii) Total number of treatments / sessions / consultations? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

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

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**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 applicants 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.

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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 application 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" what procedures are in place? \_\_\_\_\_

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ii) Has the applicant 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: \_\_\_\_\_

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

Yes  No

If "Yes" please state which and period of membership / registration: \_\_\_\_\_  
\_\_\_\_\_

12. If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance?

Yes  No

If "Yes" please give full details: \_\_\_\_\_  
\_\_\_\_\_

13. Are you currently Insured for Medical Professional Liability?

Yes  No

i) If Yes, please indicate the name of the Insurer: \_\_\_\_\_  
\_\_\_\_\_

ii) Please indicate if such coverage is offered on an occurrence basis or claims made basis.

Occurrence  Claims Made

iii) If current coverage is on a claims made basis, what is the retroactive date? \_\_\_\_\_

iv) What is your current policy limit? \$ \_\_\_\_\_

v) What is your current deductible? \$ \_\_\_\_\_

vi) If you are presently insured, are renewal terms being offered?

Yes  No

vii) If No, please state reason: \_\_\_\_\_  
\_\_\_\_\_

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

Full Time/Part Time	Branch of Medicine	Qualifications	Date Qualified
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. To your knowledge, has any company declined or terminated the insurance for you, any present partner or officer or for any predecessor in the business, past partners or officers?

Yes  No

If "Yes", provide details: \_\_\_\_\_  
\_\_\_\_\_

16. a) Have any claims ever been made to your knowledge against you, any business predecessors, or any of the present or former partners or officers?

Yes  No

b) Are you aware of any act, error, omission or circumstances which could give rise to a claim against you or any predecessor in business, or any present or former partner or officer?

Yes  No

**IF THE ANSWER TO EITHER Q.16 a) OR Q.16 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM**

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 16. a) AND/OR 16. b) OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

17. Insurance required:

- LIMITS:**
- \$ 1,000,000
  - \$ 2,000,000
  - \$ 3,000,000
  - \$ 4,000,000
  - \$ 5,000,000
  - \$ 6,000,000
  - \$ 7,000,000
  - \$ 8,000,000
  - \$ 9,000,000
  - \$ 10,000,000
  - Other \_\_\_\_\_

- DEDUCTIBLES:**
- \$ 1,000
  - \$ 2,500
  - \$ 5,000
  - \$ 10,000
  - \$ 25,000
  - Other \_\_\_\_\_

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed or misstated any material facts and I/we agree that this declaration shall be the basis of any binder or contract or insurance with the Insurer, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurer to the issue of the insurance nor the Applicant to the purchase of the insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 16. a) or 16. b) of this application, the Insurer shall be immediately notified in writing of such information.

NAME OF FIRM \_\_\_\_\_

\_\_\_\_\_  
Signature (Signing Officer)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**CLAIMS HISTORY**

Applicants Name: \_\_\_\_\_ Date: \_\_\_\_\_

Claimant: \_\_\_\_\_

Date of Loss: \_\_\_\_\_ Suit: Yes  No

Amount Claimed: \$ \_\_\_\_\_ Estimated Liability: \$ \_\_\_\_\_

Indemnity Paid: \$ \_\_\_\_\_ Expenses Paid: \$ \_\_\_\_\_

Closed: Yes  No

Description of Claim: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Claimant: \_\_\_\_\_

Date of Loss: \_\_\_\_\_ Suit: Yes  No

Amount Claimed: \$ \_\_\_\_\_ Estimated Liability: \$ \_\_\_\_\_

Indemnity Paid: \$ \_\_\_\_\_ Expenses Paid: \$ \_\_\_\_\_

Closed: Yes  No

Description of Claim: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Claimant: \_\_\_\_\_

Date of Loss: \_\_\_\_\_ Suit: Yes  No

Amount Claimed: \$ \_\_\_\_\_ Estimated Liability: \$ \_\_\_\_\_

Indemnity Paid: \$ \_\_\_\_\_ Expenses Paid: \$ \_\_\_\_\_

Closed: Yes  No

Description of Claim: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_