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Application

Errors and Omissions Insurance for Dental Clinics

Submitting Broker, please complete the following to assist us in processing this submission:

Name of Brokerage: _____

Name of Broker Contact: _____

Brokerage Address: _____ City: _____ Postal Code: _____

For renewal purposes only: Policy Number: _____ ISN (Client's Number): _____

THE APPLICANT

1. Name of Clinic: _____

   _____

   If more than one legal entity, please indicate the relationship between each: _____

   _____

   (Please note that an insurance policy cannot be shared unless there is a financial interest.)

2. Website Address (if applicable): _____

3. Address: _____

   _____

4. Location of Branch Offices: _____

5. Date operations began: _____

6. Type of Clinic (fully describe all activities of the Clinic): _____

   _____

   _____

7. Are general anaesthetics administered? YES ☐ NO ☐

   (a) If yes, is the anaesthetist present? YES ☐ NO ☐

   (b) If not, who is present and what are their qualifications? YES ☐ NO ☐

   _____

8. Please list all employees and volunteers working at the clinic and provide the name of their professional liability insurer (i.e., insured individually).

Employees/Volunteers	Duties/Discipline	Professional Liability Insurer if applicable

9. Please indicate the Applicant's gross annual revenue:

   (a) Previous Year: $_____

   (b) Anticipated for Next Year: $_____

10. Please indicate the total number of patient visits during the past year: _____

11. Please list the name and discipline of each professional working at the clinic and provide the name of the professional liability insurer of each.

Name	Discipline	Professional Liability Insurer, if applicable

Use a separate sheet if necessary.

N.B. PLEASE NOTE THAT THIS PROPOSED PROFESSIONAL LIABILITY INSURANCE FOR DENTAL CLINICS EXCLUDES PHYSICIANS, SURGEONS AND DENTISTS WHEN THEY CARRY OUT OR NEGLECT TO CARRY OUT AN ACT IN THE PRACTICE OF THEIR PROFESSION.

12. Does the Applicant provide services or perform activities outside Canada or for clients who are outside Canada? YES ☐ NO ☐

If yes, please provide full details for our review and acceptance, and indicate the services provided as well as the location and the gross annual fees or income from the past year and anticipated for the next year.

QUALITY CONTROL FOR CARE AND SERVICES

13. Is there an established system to identify risk situations? YES ☐ NO ☐

If yes, please provide details.

INSURANCE COVERAGE - **If you are renewing your policy with Victor, do not complete this section.**

14. (a) Has the Applicant ever previously purchased professional liability or errors and omissions insurance? YES ☐ NO ☐

(b) If yes, please provide the following details for the last three years:

Insurer	Policy Period	Expiring Premium	Limit	Deductible
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____

(c) With respect to (b) above, please indicate if such coverage was offered on an occurrence basis or claims-made basis:

If claims-made, what was the retroactive date of the policy (dd/mm/yyyy)? _____

15. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused? YES ☐ NO ☐

If yes, please provide details.

LOSS EXPERIENCE - **If you are renewing your policy with Victor, do not complete this section.**

16. (a) In the past, has the Applicant or any of their employees ever been the recipient of any allegations of professional negligence in writing or verbally? YES ☐ NO ☐

(b) Is the Applicant or any of their employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? YES ☐ NO ☐

If yes, please provide details.

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURERS, 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.

LIMITS REQUESTED

17. Per claim: $_____ Per policy period: $_____ Deductible: $_____

Please note that the proposed insurance will be effective at a date determined by the insurers.

APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM

I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to Victor Insurance Managers Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize Victor Insurance Managers Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on Victor's privacy policy, please contact privacypolicyinquiries@victorinsurance.com.

DECLARATIONS AND SIGNATURE

The undersigned Applicant for this insurance declares that, to the best of their 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 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 further 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.

Name of Applicant (please print)

Signature of Applicant

Date (dd/mm/yyyy)