

Application Intact Insurance Company

Coverage Effective Date (dd/mm/yy) as of 12:01 am

Time stated is local at the applicant's address _____

Your Name _____

Address _____

City _____

Province _____

Postal Code _____

Phone Number _____

Business Number _____

FAX Number _____

Email Address _____

Website _____

How long have you been a practising chiropractor? (years) _____

College or university attended and date of graduation _____

In which province(s) are you registered as a Chiropractor? _____

Registration # _____

Do you practice Chiropractic or other health care services outside Canada? Yes No

If yes, in what other countries? _____

Location where each patient record of recorded treatments is stored? Clinic Home

If Other, please specify _____

Are all new patients requested to sign an "Informed Consent"? Yes No

Does your practice include any of the following?

Needle Insertion Acupuncture? Yes No

Naturopathy / Homeopathy? Yes No

Animal Care Chiropractic? Yes No

If yes to any of the above, please specify in detail here: _____

Are you involved in any other health care delivery apart from any of the above disciplines? No

Yes please specify type and % of gross fees: _____

Have you ever been suspended or prohibited from practising chiropractic or do you have any registration restriction? No

Yes If yes, describe: _____

During the prior year, have you carried professional liability insurance, and if so with which company or organization? No

Yes If yes, describe: _____

Has any similar insurance applied for, or carried by you, been declined or cancelled by any insurer within the previous six (6) years? No

Yes If yes, describe: _____

Has any similar insurance applied for, or carried by you, been declined or cancelled by any insurer within the previous six (6) years? No

Yes If yes, please specify in detail here: _____

During the previous six (6) years, have you been the object of one or more claims, have you given notice of a possible claim to any insurer, or have there been any incidents not yet reported to an insurer that may result in claims against you? No

Yes If yes, please specify in detail here: _____

For the purpose of this application the word "Claims" used in question 15 shall mean:

- A) A verbal or written claim for money damages**
- B) A verbal or written allegation**
- C) A fact or circumstance which could reasonably give rise to a claim for money damages**

Are you a member of any health care related association? AFC CNAC
I.C.A. WCA
 Please advise if your weekly hours of practice are 20 hours or less? Yes No

Malpractice Limit Requested

- \$5,000,000. Per Claim/\$5,000,000 Aggregate Limit
Note: Prior Acts is included only if there has been continuous Chiropractic Professional Liability Insurance in place prior to the inception date of the policy to be issued.
- CHIROPRACTIC CARE TO ANIMALS COVERAGE** \$5,000,000. Per Claim/\$5,000,000 Aggregate Limit
Note: Qualification for this coverage is based upon completion of a course in Animal Chiropractic recognized by the Provincial Chiropractic Licensing Board in the policyholder's jurisdiction.
- NEEDLE INSERTION ACUPUNCTURE COVERAGE** \$5,000,000. Per Claim/\$5,000,000 Aggregate Limit
*Acupuncture & Homeopathy/Naturopathy, Chiropractic Care To Animals limits must concur with Chiropractic limit chosen
- HOMEOPATHY / NATUROPATHY COVERAGE** \$5,000,000. Per Claim/\$5,000,000 Aggregate Limit
- NEW GRADUATE** \$5,000,000. Per Claim/\$5,000,000 Aggregate Limit
New Graduates Only – Retroactive Commences at Inception Date
- STUDENT REGISTRANT** \$5,000,000. Per Claim/\$5,000,000 Aggregate Limit
only under the supervision of a full registrant Retroactive Commences at Inception Date

The applicant hereby declares that the above statements are exact, complete and true in every particular. If an insurance contract is affected, the statements set forth herein shall be the basis of the contract of insurance and shall become an integral part of the policy.

Signature _____ Dated _____

Please answer all questions and leave no blank spaces. If the space provided is insufficient to answer any question fully, kindly append a separate sheet.

Are you interested in receiving a quote for your Cyber Coverage?

If you would like a cyber quote, please provide the following details:

Gross Revenues _____

Number of Employees _____

Preauthorized Payment Plan Intact Insurance Company

Prerequisite for Preauthorized Payments: to ensure accuracy, please enclose a specimen cheque marked "void". Do not forget to indicate your account number and mail to the insurer.

To the Financial Institution:

I, the undersigned hereby authorize the insurer named above, to draw monthly cheques or prepare debits by paper or electronic entry, payable to the order of the insurer, covering the premium due. It is understood and agreed that the amount of premium may fluctuate in accordance with changes made to the policy. You are hereby authorized to pay and debit the account number mentioned below.

1. All amounts payable to the above-mentioned insurer drawn on or directed to you by a chartered bank on behalf of the insurer.
2. Your treatment of each debit shall be the same as if the undersigned has personally directed you to pay as indicated and to charge the amount specified to the account of the undersigned.
3. The authorization may be cancelled at any time upon 10 days written notice sent to the insurer. In such a case, any outstanding balance becomes due and payable immediately.
4. Any delivery of this authorization to you constitutes delivery by the undersigned.

*** For a joint account, all depositors must sign if more than one signature is required on cheques issued against the account. ***

Name (print) _____ Account Number: _____

Signature _____ Dated _____

as shown in the financial institution records.

TO BE RETURNED WITH A SPECIMEN CHEQUE MARKED "VOID".

Disclaimer

The applicant hereby acknowledges that the Brokerage has been retained by the applicant to acquire or renew a policy or policies of insurance or to provide Consulting and/or Risk Management Services for the applicant, under which the individual applicant or named individuals in addition to the applicant or where the applicant is a commercial or other entity, its employees, servants and representatives (hereafter collectively called "insured individuals") may be insured.

As part of the application for new or renewal insurance coverage(s), the applicant hereby authorizes the Brokerage to collect, use and disclose personal information of such insured individuals as required and as permitted pursuant to relevant privacy laws or other laws.

The applicant hereby expressly consents to the Brokerage collecting using or disclosing personal information of such insured individuals or providing such personal information to third parties as required, including insurance companies. Where there are insured individuals in addition to the applicant or where the applicant is a commercial or other entity, the applicant hereby covenants and warrants that the applicant has obtained the appropriate consent from all of the insured individuals to disclose their personal information to the Broker for these purposes accordingly.

If the applicant wishes to restrict the general nature of this consent to any specific area, please indicate:

If the applicant wishes:

- to review personal information maintained by the Brokerage pertaining to the applicant's application policy or policies.
- to obtain copies of the Brokerage's privacy policies or standards; or
- to make other enquires or to express concerns,

the applicant may do so by contacting the Brokerage.

IMPORTANT: This type of insurance coverage only applies to claims made to the insurer during the policy period except, evidently those claims relating to known negligent acts or also to known facts or circumstances which have occurred and are likely to give rise to an eventual claim. Therefore, if you presently hold an insurance contract on a "claims made" basis, make sure to report to your insurer known negligent acts or any fact or circumstance which could give rise to an eventual claim, and this to enable you to conform to the application of the coverage, for which there is an obligation to report to the insurer "during the policy period".

Please email this application to commercialprograms@westlandmygroup.ca or fax to 1-866-966-0969. If you have any questions, please call us at 1-844-999-7687 ext. 2175. Your policy documents will follow shortly. Thanks for your business!

I would like to receive additional insurance information that may benefit me and/or my business.