LLOYD'S

Professional and General Liability Application

Effected with certain Lloyd's Underwriters ("Insurers")
through Lloyd's approved Coverholder:
Holman Insurance Brokers Ltd.
3100 Steeles Ave. E Suite 101, Markham, Ontario L3R 8T3
(Defined herein as "THE COVERHOLDER")

Canadian Naturopathic Doctor Professional And General Liability Insurance Application Form

NOTE: THIS APPLICATION IS AN IMPORTANT DOCUMENT AND IS BEING RELIED ON BY THE INSURER TO DETERMINE WHETHER IT WILL PROVIDE YOU WITH COVERAGE. PLEASE ENSURE THAT ALL RESPONSES ARE ACCURATE. THIS DOCUMENT WILL FORM PART OF YOUR POLICY.

"**Applicant**" means the individual practitioner detailed in question 1 overleaf below. This application form must be completed in ink, signed and dated by the **Applicant**. Please attach an updated and relevant resume/CV together with certificates proving all relevant qualifications in respect of this application. All questions must be answered and where appropriate "Not Applicable" or "N/A" specified. The completed application form along with additional information provided will form part of the contract of insurance with the Insurers. All facts material to the proposed insurance must be disclosed fully and truthfully and to the best of the **Applicant**'s knowledge and belief whether or not they are the subject of a specific question herein. In addition to the information contained in the application form including all supporting documentation, if the **Applicant** is aware of any other information which it considers may alter, influence or prejudice the Insurers' appraisal of the risk being proposed, this information must be disclosed in conjunction with this application form.
By signing this application form the **Applicant** is consenting to the use of information, including sensitive personal information. Where personal information relates to third parties, the **Applicant** confirms that it has been given the requisite consent to disclose such information to the Insurers for processing.
If there is insufficient space to complete an answer to any question in this application form, please continue on the continuation space (and additional page) provided, which should then be signed, dated, and attached to this application form.

COVERAGE PART A – PROFESSIONAL LIABILITY – "Claims Made"
This insurance under Part A, is underwritten on a "claims made" basis, which means that if a claim is made against the **Applicant** then the **Applicant** MUST have a current policy in force. Any claims brought against the **Applicant** after the expiry of the policy period (or any specific run-off extension or extended reporting period) will NOT be covered.

Insuring Clauses Available
Policy Limits up to $5,000,000 per Claim, $10,000,000 in the aggregate are available across the following covers:

- Professional Negligence
- Libel & Slander
- Infringement Of Copyright
- Breach Of Confidentiality
- General Liability To Third Parties
- Rescuers & Good Samaritan Acts

In addition, the following are automatically included:

- $250,000 Duty To Refer To Healthcare Service Providers
- $100,000 Products Liability For e.g. Herbal Remedies
- $250,000 Loss Of Documents

COVERAGE PART B – OPTIONAL - COMMERCIAL GENERAL LIABILITY POLICY – "Occurrence Basis"
Comprehensive General Liability is available as an optional addition to coverage part A. Coverage under part A must be purchased for this additional Part B to apply. Insurance is on an "Occurrence Basis".

Qualifications
In the event of a claim, the **Applicant** will be required to produce qualification certificates.

Approved Associations
This application applies only to the activities specifically detailed below by the **Applicant**, AND for which the **Applicant** has an approved relevant qualifications from **The Canadian College of Naturopathic Medicine (CCNM) OR THE Boucher Institute of Naturopathic Medicine (BINM). ND's in Ontario must be registered with Board of Directors Drugless Therapy Naturopathy – BDDT-N, other provinces Alberta AANP/CNDA, Manitoba MBND, Saskatchewan SANP, Nova Scotia NSAND and British Columbia CNPBC.**

Applicant Acknowledgement

Signature _____ Date _____

WARNING
If the Applicant receives a claim or becomes aware of a circumstance that may give rise to a claim, the Applicant must contact Holman Insurance Brokers Ltd. immediately to ensure that the claim notification provisions under the policy are adhered to. Failure to do so could prejudice the Applicant's ability to claim under the Applicant's insurance policy.

If the Applicant is a new client to Holman Insurance Brokers Ltd. and the Applicant's previous liability policy was not on a claims made basis with the same retro-active date to that provided under this insurance application please call Holman Insurance Brokers Ltd. for advice as the Applicant may be exposed to a gap in cover.

Personal Information of The Applicant (You) - Please provide the following specific information:

Any **Applicant** who has qualified overseas shall also have to be individually approved prior to cover being authorized by Insurers.

1.	Full Name Of **Applicant**:	First Name	Initial	Last Name

2a.	Address:	Street Address		
		City	Province	Postal Code

b.	Telephone Number:	Business #	Cell #

c.	Email Address:	Fax #

3. Relevant Canadian Qualifications – **PLEASE ATTACH CERTIFICATES**

Name of Association, School or Centre	Course Title	Dates MM/DD/YY

Relevant Non-Canadian Qualifications - **PLEASE ATTACH CERTIFICATES**

Name of Association, School or Centre	Course Title	Country	Dates MM/DD/YY

Any **Applicant** who has **Non-Canadian qualifications** will have to be individually approved prior to cover being authorized by Insurers.

3.

Associations that you are a current subscribing member of (Including membership Nos):-

Name of Association	Membership No.	Date First Joined	Membership Type

Please provide evidence of current membership (e.g. Annual Certificate). Please note that if the **Applicant** is not a member of any of the approved associations, there is no automatic cover and the application will have to be reviewed and specifically authorized by the Insurers, and even if the authorization is approved the detailed premiums may not still apply.

MM/DD/YY

4. Date Of Birth:-

MM/DD/YY

5. Date Started Practice:

6. Is any of your work supervised? ☐ Yes ☐ No

If **YES**, Please advise by whom and under what circumstances:

Name of Supervisor	Address	Tel #	Email
Please provide qualifications of supervisor			

7. a. Do you work with animals? ☐ Yes ☐ No

If **YES**, please advise when this would happen and with what types of animal.

b. Are you a student or a candidate for admission to a profession, or an intern or any such other occupation that includes elements of educational tutelage? ☐ Yes ☐ No

Where the **Applicant** is a student or candidate for admission to a profession, or an intern or any such other occupation that includes elements of educational tutelage, it is a condition precedent to the right to be indemnified under this policy that the **Applicant** be under the supervision of a practitioner/instructor qualified within the activities covered and is restricted to performing practice treatments or case work only, and that the **Applicant** advises the recipient of such treatments (or their parent or legal guardian, if the recipient has not attained the age of 16) and that they are receiving treatment as part of a training program. The **Applicant** must not offer treatments outside of their capabilities which shall at all times be governed by the phase reached in their training program and their supervising instructor/practitioner's assessment.

If **YES**, Please advise name of qualified practitioner or instructor.

Name of qualified practitioner of instructor	Address	Tel #	Email

Please provide qualifications of qualified practitioner or instructor.

c. Do you provide sports therapy / rehabilitation / massage therapy or personal fitness instruction to Professional Sports persons and/or dancers? ☐ Yes ☐ No

d. Do you teach and/or certify or qualify another to teach others? ☐ Yes ☐ No

Where an applicant is a teacher, teaching is considered certifying and/or qualifying another to teach others. Not to be confused with instruction of others in participation of an activity.

Your policy does not extend coverage to the actions of your students. Examples of this would be:
i) a student injuring another student during practical training;
ii) a student or graduate causes harm to a patient and an allegation is made that the damages were in whole or in part as a result of insufficient or deficient training.

If **YES**, how often and to whom.
Attach relevant qualifications.

To Whom?	How often?

e. Do you undertake surgical treatments? If YES, please provide details below. ☐ Yes ☐ No

f. Do you prescribe pharmaceuticals to patients that require a recognized medial prescription? ☐ Yes ☐ No

g. Do you require liability coverage for any additional Insureds? Please indicate the relationship, state name and full address. If more space is required, please complete on a separate form. ☐ Yes ☐ No

NOTE: If the answers to item 7 a – f are **YES**, an additional premium loading will apply. Please refer to premium calculation page.

8. Do you keep records for at least 7 years for all patients/clients? ☐ Yes ☐ No

If **NO**, please advise why the answer is **NO**:

9. Do you obtain satisfactory consent in writing from each patient prior to starting treatment? ☐ Yes ☐ No
If **YES**, please attach sample copy of consent form, intake form or client waiver.

10. Have any negligence claims ever been made against you whether successful or otherwise? ☐ Yes ☐ No

11. Have any claims for dishonesty ever been made against you whether successful or otherwise? ☐ Yes ☐ No

12. Have any complaints or investigations ever been made or undertaken against you? ☐ Yes ☐ No

13. Have you ever had a document relating to the **Applicant's** activities unintentionally destroyed, damaged, lost or mislaid? ☐ Yes ☐ No

14. Has the **Applicant** ever been convicted of a criminal offence, other than a motoring offence, or have any prosecution pending? ☐ Yes ☐ No

15. Have any libel or slander claims, infringement of copyright or breach of confidentiality ever been made against you? ☐ Yes ☐ No

16. Have any sexual harassment and/or abuse claims ever been made against you? ☐ Yes ☐ No

17. Are you aware of any circumstances which may give rise to a potential claim or request for indemnity under this professional liability insurance? ☐ Yes ☐ No

NOTE: If the answer to any of 10-17 above is **YES**, please provide full details:

18. Do you currently purchase Liability, Medical Malpractice and/or Professional Liability Insurance? If YES, please give full details: ☐ Yes ☐ No

LIMIT:	DEDUBTIBLE:	EXPIRY DATE MM/DD/YYYY	TYPE OF INSURANCE	PREMIUM

If you had a "Claims Made" policy and require retro date coverage, please provide evidence of prior insurance policy.

19. Have you ever had a claim made against you whether successful or otherwise in respect of bodily injury, property damage, premises (including tenant's liability), liability, personal injury, advertising liability or medical expenses? If YES, please give full details:

ND Therapies

The policy being applied for covers the following activities as defined by Board of Directors of Drugless Therapy – Naturopathy (BDDT-N):

☐ A) Diagnostic procedures including, but not limited to:
- Case History
- Physical Examination using standard medical diagnostic equipment and including breasts and genitalia
- Laboratory Diagnosis including blood, urine, stool and cultures.

☐ B) Therapeutic procedures include the integrated use of:
- Clinical Nutrition including dietary recommendations and nutritional supplementation
- Botanical medicine
- Oriental Medicine and Acupuncture
- Homeopathic medicine
- Mechanotherapy including Manipulation of the Spine and Extremities
- Lifestyle Modification and Public health.
- Physical Therapeutic Procedures including heat/cold, light, ultraviolet, infrared, electrical pulsation, magnetic field, therapeutic ultrasound, diathermy, interferential, cold laser, hydrotherapy, colon therapy, traction, naturopathic massage, exercise and other.
- Counseling

C) If the Insured has been approved by BDDT-N to provide these services. **Please ☑ all therapies that you are qualified for.**

☐ Bowen Therapy, ☐ CranioSacral Therapy, ☐ Nambudripad's Allergy Elimination Techniques NAET, ☐ Allergy/Sensitivity Challenge Testing

☐ Other, please specify: _____

NOTE: Parenteral procedures and therapies are specifically excluded hereunder. If you require cover for this specific type of activity, please call Holman Insurance Brokers Ltd.

Additional TCM Therapies (if required)

The following therapies can be covered if you are required to be licensed under Transitional Council of the College of Traditional Medicine Practitioners and Acupuncturists of Ontario -TC-CTCMPAO:

Traditional Chinese Medicine **Please ☑ all therapies that you are qualified for:**	**Related Professional Services** **Please ☑ all therapies that you are qualified for:**
☐ Acupuncture – single use disposable needles *	☐ Allergy Testing
☐ Acupuncture – using laser / electro devices	☐ Ayurveda
☐ Acupressure	☐ Bio Feedback
☐ Aromatherapy	☐ Ear Candling - $50 loading applies
☐ Auriculotherapy	☐ Iridology - $50 loading applies
☐ Chinese medicine counseling	☐ Nutrition Therapy
☐ Dispensing of herbs and herb granules	☐ Reflexology - $50 loading applies
☐ Cupping	☐ Reiki
☐ First Aid	☐ Shiatsu
☐ Heat Therapy	☐ Yoga
☐ Holistic Counseling	**FOR AN INDIVIDUAL ACTIVITY IS NOT LISTED ABOVE.**
☐ Magnetic Therapy	If an individual activity does not appear in the list above and requires cover, please provide full details below including details of training, accreditation and course syllabus details. (Such activity will have to be specifically agreed and approved by Insurers prior to cover being granted). Please submit this application to the Coverholder for rating.
☐ Massage Therapy	
☐ Moxibustion	
☐ Qi Gong	
☐ Skin Scrapping	
☐ Spiritual Therapy	
☐ Tai Chi	☐ Others (please list) – additional load may apply
☐ Tapas Acupressure	_____
☐ Therapeutic Touch	_____
☐ Tuina	_____
☐ Wu Head Massage	
☐ Zen Therapy	

PREMIUM CALCULATION

Policy coverage starts at $1,000,000 for any one claim, capped at $2,000,000 for all claims (aggregate) made during the policy period. Higher limits as detailed below are available and the **Applicant** should discuss specific requirements with the Coverholder if in any doubt as to the adequacy of the limits being considered. Subject to a satisfactory application, the **Applicant** will be charged the following:

THERAPIES AND LIMIT TO BE COVERED

COVERAGE – A –" Claims Made" Professional & General Liability

Please select and check off the required limit and category. Write the applicable premium in the column. ▼

	▼ Check those that apply ▼			
▼ **Check off one LIMIT OF INDEMNITY**	☐ **ND Rates**	☐ **TCM Extension**		**PREMIUM**
☐ **$1,000,000 Per Claim, $2,000,000 Aggregate**	**$440.00**	**$180.00**		**$**
☐ **$2,000,000 Per Claim, $4,000,000 Aggregate**	**$500.00**	**$200.00**		
☐ **$2,000,000 Per Claim, $5,000,000 Aggregate**	**$525.00**	**$275.00**	**ONTARIO MINIMUM REQUIREMENT FOR ND, TCMA**	
☐ **$3,000,000 Per Claim, $6,000,000 Aggregate**	**$550.00**	**$310.00**		
☐ **$5,000,000 Per Claim, $10,000,000 Aggregate**	**$650.00**	**$400.00**		

If the following activities are undertaken the above premiums will be increased with the **following additional premium loading:**

▼If you answered YES to questions 7.d, 7e, and/or 7f loading applies. **Check off all that apply.**		**LOADING**	
☐ **Teaching - Question 7.d**	**ADD**	**50%**	**$**
☐ **Surgery - Question 7.e**	**ADD**	**75%**	**$**
☐ **Prescriptions - Question 7.f**	**ADD**	**30%**	**$**

TOTAL PART A	**$**

COVERAGE – B – (OPTIONAL) – Commercial General Liability – "Occurrence Basis"

▼ **Check off one.** ***Please select and check off the required limit. Write the applicable premium in the column.*** ▼

Limit	**Annual Premium**	**PREMIUM**
☐ **$1,000,000 per Claim / $1,000,000 Aggregate**	**$95**	**$**
☐ **$2,000,000 per Claim / $2,000,000 Aggregate**	**$145**	
☐ **Additional Insured – Question 7.g.**	**$50 per additional insured**	**$**

included above:

- $1,000,000 Personal & Advertising Injury Liability
- $5,000 per person/$10,000 per claim Medical Expenses
- $500,000 Tenant's Legal Liability

TOTAL PART B	$

TOTAL PART A & B	$
For residents of Manitoba add 7% Quebec add 9% Ontario add 8% **TAX**	**$**
TOTAL INCLUDING TAX	**$**

All premiums are annual and 100% retained. Policy is subject to a $1,000 Deductible

Please advise the date insurance required is to be effective:	MM/DD/YYYY

NOTE: COVERAGE CAN ONLY BE BOUND AND CONFIRMED BY HOLMAN INSURANCE BROKERS LTD.

Protection of the Applicant's Personal Information:
By completing this application and returning it to Holman Insurance Brokers Ltd., the **Applicant** agrees and consents to the collection, use and disclosure of such information, including any personal information, by Holman Insurance Brokers Ltd. For the following purposes:

- Communicating with the **Applicant**
- Assessing the **Applicant**'s application for insurance
- Disclosing information to Insurance Companies
- Negotiating, maintaining or renewing insurance on the **Applicant**'s behalf
- Providing claims assistance and service.
- Advising the **Applicant** of other products or services
- Complying with regulators and legal authorities

For more information about our privacy policies and practices or for a copy of our Privacy Policy please visit our web site www.holmanins.com or contact our Privacy Officer at Holman Insurance Brokers Ltd.

DECLARATION
I/we declare that the above statements are true in every respect. I/we hold qualification certificate(s) for the therapy(ies) stated on this application form. I/we have not withheld or misrepresented any material fact. I/we agree that this application will form the basis of the contract between me/us and Holman Insurance Brokers Ltd.

Applicant's Signature **Date**

Naturopathic Doctor Professional and General Liability Checklist

Application completed in full. All questions must be answered. ☐

All pages #1 to #8 must be returned. (including page #1). ☐

Relevant certificates and qualifications attached.(see question #3) ☐

Membership Documentation (e.g. Certificate of Membership). ☐

Copy of prior insurance policy if prior retro date is required. ☐

Resume cv attached. ☐

Sample patient, client intake and consent forms attached. – page 4 question 9 ☐

Categories – (page 5) – all applicable have been checked off. ☐

Premium calculation including tax for options– page 7. ☐

☐ cheque attached ☐ online Bank confirmation #_____ if online Name of Bank _____

PAYMENT OPTIONS

Internet Banking

Each bank has designed a unique format for their web site. However, the necessary procedures are generally similar.

1. Under Bill Payment: Choose Add Payee/Bill.
2. Enter Holman. Choose All Categories and province Ontario and submit.
3. Under Bill company/Payee - Select Holman Insurance Brokers Ltd. and enter your account number which is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
4. Select the account you wish to withdraw the funds from. (i.e. credit card, savings, chequing, line of credit). Indicate the amount of payment and submit. A confirmation and reference number will be displayed to acknowledge your payment.

Telephone Banking

1. Request your bank to set up a new Payee/Bill to do a Bill Payment.
2. Request the addition of a new Payee/Bill Company: Holman Insurance Brokers Ltd.
3. Your account number is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
4. Your banking institution will then take your payment over the telephone by your choice of payment method.

Debit Card Payments

1. Contact your bank by telephone or visit in person. Request that they set up an option to allow you to make Bill Payments by Debit Card.
2. Request the addition of a new Payee/Bill Company: Holman Insurance Brokers Ltd.
3. Your account number is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
4. Once you have set up Holman Insurance Brokers Ltd., you are able to proceed with payments via your branch ATMs with your debit card.
5. Choose banking option: Bill Payment and follow your bank instructions.

In Person at the Bank

1. At your own bank, request they set up a new Payee/Bill to do a Bill Payment.
2. Request the addition of a new Payee/Bill Company: Holman Insurance Brokers Ltd.
3. Your account number is THE FIRST FOUR LETTERS OF YOUR LAST NAME FOLLOWED BY XX1
4. You can choose to pay via the different accounts you hold with that particular bank or by other financial institution credit cards.
5. When paying in person at different financial institutions, bring your invoice/statement and request to make a Bill Payment.
6. Advise the teller that the Payee is Holman Insurance Brokers Ltd. and follow the prompts from step #2.

Note: Do not ask for a wire transfer or funds transfer, the banks charge you extra for this service and charge us extra for which we do not reimburse. These additional fees can range as high as $50 or more.

By Mail

Cheque or money order payable to:
Holman Insurance Brokers Ltd.
3100 Steeles Ave. East Suite 101
Markham ON L3R 8T3