



INSURANCE FOR ALLIED HEALTH & MEDICAL PROFESSIONALS

MedSurance™ A&M Application Form

This is an application for errors and omissions package policy aimed at a wide range of complementary medical practitioners. As well as errors and omissions the policy includes sexual misconduct and physical abuse liability, general liability and property. Limits are available up to \$5,000,000 and worldwide cover is provided as standard. Simply complete the form and return it to your insurance broker.



CFC Underwriting

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INSURANCE FOR ALLIED HEALTH & MEDICAL PROFESSIONALS

APPLICATION FORM

INTRODUCTION

The purpose of this application form is for us to find out who you are and to obtain information relevant to the cover provided by the MedSurance™ A&M policy. Completion of this application form does not oblige either party to enter into a contract of insurance. Insurance is a contract of utmost good faith. This means that the information you provide in this application form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your application for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed. If a contract of insurance is agreed between you and us this application form will form the basis of the contract.

Important: Some Insuring Clauses of this Policy provide cover on a claims made basis. Under these Insuring Clauses a claim must be first made against the Insured and notified to us during the period of the policy to be covered. These Insuring Clauses do not cover any claim arising out of any actual or alleged wrongful act occurring before the Retroactive Date.

HOW TO COMPLETE THIS FORM

Whoever fills out the form must be a principal, partner or director of the applicant firm and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered. If you require any extra room to complete the answers to questions contained within this application form please continue your response in the Additional Information section at the back of the form. Once you have completed the form please return directly to your insurance broker.

SECTION I: COMPANY DETAILS

1.1 Please state the name and address of the principal Company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal Company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form:

Insured company:	
Contact name:	
Address:	
ZIP code:	
Telephone:	Email address:
Fax:	Website:

1.2 Please state when your company was established:

MM / DD / YY

1.3 a) How many directors / officers / partners are there in the Company?

b) Please show the details of all partners / directors:

Name	Years in position	Years experience	Qualifications

2.3 Do you belong to any association related to these activities? Yes No
If yes, please list these associations below:

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2.4 Is any legislation currently in force governing your activities? Yes No
If yes, please provide details:

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2.5 Do you verify professional certificates or licenses of all employees and independent contractors? Yes No
If no, please explain:

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2.6 In the event that your product or service failed or delivery was delayed please describe the worst case scenario. Consider the potential for loss of life, injury to people, damage to buildings or other tangible property, or financial loss (consequential or otherwise) for your clients:

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Only complete question 2.7 if you also require a quote for General Liability.

2.7 Please state the following:

a) Your total estimated payroll for the next financial year:

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b) Your payroll relating to non-manual work away from your premises (such as consulting or similar):
Please detail the nature of this work below:

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c) Your payroll relating to manual work away from your premises:
Please detail the nature of this work below:

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d) Your payroll relating to hazardous work away from your premises:
Please detail the nature of this work below:

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3.4 Please detail the amounts to be insured below for each premises:

NOTE: The amounts insured you state below should be the full rebuilding or replacement cost in each of the categories. If you understate these amounts you will be under-insuring and we may not pay the full amount of your claim. It is therefore essential that these amounts are as close to the true values of the insured items as possible.

ITEM	AMOUNT INSURED PREMISES 1	AMOUNT INSURED PREMISES 2
Main building:	_____	_____
Landlord's fixtures & fittings and tenant improvements:	_____	_____
Personal computers, printers and ancillary computer equipment at your premises:	_____	_____
All other contents at your premises:	_____	_____
Portable computers and associated equipment at home / away from your premises:	_____	_____
All other contents at home / away from your premises:	_____	_____

3.5 Please state, in respect of portable computers and associated equipment at home / away from your premises, the maximum value of any one item (not the total value of all items):

3.6 Please detail the amounts to be insured below for business interruption cover. Note that the maximum indemnity period available is 12 months. You should bear in mind how long it will take you to re-commence trading at another premises when stating the amount insured and indemnity period.

We provide our business interruption cover on a flexible first loss basis – please specify a total amount insured for business interruption cover. This amount applies regardless of whether your business interruption loss is loss of income, extra expense, or accounts receivable. This often enables a smaller total amount insured to be specified and therefore often results in a cheaper premium:

ITEM	AMOUNT INSURED	INDEMNITY PERIOD
Business Interruption Cover (flexible first loss):	_____	_____

SECTION 4: CLAIMS EXPERIENCE AND INSURANCE HISTORY

4.1 Please provide details of your current Errors and Omissions insurance, if applicable, and what you require for the next year of insurance:

	Retroactive date	Effective date	Limit	Deductible	Premium	Insurer
Current:	MM / YY	MM / YY	_____	_____	_____	_____
Required:	MM / YY	MM / YY	_____	_____	N/A	N/A

4.2 Please provide details of your current General Liability insurance, if applicable, and what you require for the next year of insurance:

	Effective date	Limit	Deductible	Premium	Insurer
Current:	MM / YY	_____	_____	_____	_____
Required:	MM / YY	_____	_____	N/A	N/A

4.3 Regarding all of the types of insurance to which this application form relates, **AFTER ENQUIRY:**

- a) are you aware of any loss or damage, whether insured or not, that has occurred to any of the Companies to be insured (or to any existing or previous business of the partners or directors of any of the Companies to be insured) within the last 5 (five) years, or
- b) are you aware of any circumstances which may give rise to a claim against any of the Companies to be insured or any partners or directors thereof, or
- c) have any claims or cease and desist orders been made against any of the Companies to be insured, or partners or directors thereof, or
- d) have any partners or directors of the Companies to be insured been found guilty of any criminal, dishonest or fraudulent activity or been investigated by any regulatory body?

With reference to questions a, b, c and d above: Yes No

If the answer to the above is 'Yes', then please attach full details including an explanation of the background of events, the maximum amount involved or claimed, the status of the claims or circumstances and any reserves or payments made by you or by Insurers, and the dates of all developments and payments.

SECTION 5: DECLARATION

- I declare that after proper enquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact.
- I agree that this Application Form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.
- I undertake to inform Underwriters of any material alteration to these facts occurring before the completion of the contract.

Signed: _____	Full Name: _____
Position held at Insured: _____	Date: MM / DD / YY

ADDITIONAL INFORMATION:

A&M



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