

COMPLEMENTARY HEALTH CARE PRACTITIONERS

APPLICATION FOR PROFESSIONAL & GENERAL LIABILITY

THIS APPLICATION IS FOR AN OCCURRENCE POLICY

ALL QUESTIONS MUST BE ANSWERED COMPLETELY. INDICATE "N/A" IF A QUESTION IS INAPPLICABLE. IF THE SPACE PROVIDED IS INSUFFICIENT TO ANSWER A QUESTION FULLY, PLEASE ATTACH A SEPARATE SHEET.

FULL NAME OF INSURED

ADDRESS		
		POSTAL CODE
TELEPHONE	CELL PHONE	
FAX NUMBER	EMAIL	

In what branches of complementary healthcare are you qualified to practice? Please indicate percentage of each – must equal 100%.

Acupressure		Crystal Healing	
Cranial Sacral	Aromatherapy	Raindrop Therapy	Nutritional Consulting
Hellerwork	Energy Work	Therapeutic Touch	Sound Therapy
Gi-Gong	Hydrotherapy	Polarity Therapy	Reiki
Esthetics ***	Reflexology	Iridology	Healing Touch
Chair Massage	Other ***	Colour Therapy	Shiatsu
Yoga/Pilates	Personal Trainers		Osteopathy
	(Can-Fit Pro Certified)		

***Please provide details and brochure if available for esthetics practices

BACKGROUND INFORMATION

For those services indicated above, please provide full details of educational qualifications and attach a copy of your certificate

Please provide description of any products manufactured, distributed or sold.

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Do you provide services outside of Canada? Yes No

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PREVIOUS INSURANCE INFORMATION

Insurance Company	Policy Limit	Policy Period	Occurrence Form OR	Claims Made**

**IF YOUR EXISTING POLICY IS A CLAIMS-MADE POLICY, YOU MAY PURCHASE AN OPTION UNDER THIS INSURANCE TO PROVIDE A ONE YEAR RETRO-ACTIVE CLAUSE WHICH WILL EXTEND COVERAGE UNDER THIS POLICY FOR ONE YEAR PRIOR TO EFFECTIVE DATE. YOUR EXISTING CLAIMS MADE POLICY MAY ONLY PROVIDE COVERAGE FOR 15 DAYS FROM THE DATE OF EXPIRY OR CANCELLATION.

Has insurance ever been declined, cancelled or renewal thereof been refused? Yes No

If yes, please provide details.

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Please provide details of all losses in the past three years. If none, check here

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Do you have knowledge of any circumstance which could result in a claim or suit being brought against the you?

Yes No If yes, please provide details

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WITHOUT LIMITATION OF ANY REMEDY AVAILABLE TO THE INSURER, IT IS HEREBY 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.

EFFECTIVE DATE OF COVERAGE

Coverage will be in force the day after we receive your application. If you wish to have a specific date, please indicate below:

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NOTICE CONCERNING PERSONAL INFORMATION

I hereby consent to Lackner McLennan Insurance to collect, use and disclose personal information required for the purposes of considering my application for insurance for new or renewal insurance coverage. The Broker is authorized to collect, use and disclose personal information and provide such personal information to third parties, as required, including insurance companies. The Broker may also be required to disclose such personal information pursuant to relevant privacy laws or other laws.

WARRANTY STATEMENT

By submitting this Application, you attest that the application has been completed accurately and honestly. No disciplinary action has been or is pending against you. You have never been the subject of any investigation, either civil or criminal, in connection with any sexual act, conduct, molestation and/or assault. You understand that your insurance certificate will provide evidence that you have been added as an individual participant with respect to the coverage and limits of the Master Policy. You understand that the coverage provided by your insurance certificate is subject to all the terms, conditions and exclusions contained in the Master Policy. You further understand that the Insurance Company will rely on the information you have provided in the Application. Failure to pay required premiums and/or false statements on this Application or subsequent renewals shall void this Application and render your insurance coverage null and void and you may be subject to further legal action for making false statements.

Signature		Dated	
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SHAWSABEY AND ASSOCIATES LTD

1710 – 1066 West Hastings Street, Vancouver, BC V6E 3X1
 Phone: (604) 689-2441 Fax: (604) 331-0662
 Toll Free: 1-800-684-1911

PROFESSIONAL & GENERAL LIABILITY APPLICATION

PLEASE SEND YOUR COMPLETED APPLICATION, COPIES OF CERTIFICATES AND PAYMENT TO THE ADDRESS

***PLEASE NOTE THAT THIS QUESTION MUST BE SIGNED AND DATED (see below)

COVERAGE LIMITS	THIS IS AN OCCURRENCE FORM POLICY	
PROFESSIONAL LIABILITY	\$1,000,000	NO DEDUCTIBLE
LEGAL EXPENSE FOR ABUSE**	\$25,000	NO DEDUCTIBLE
COMMERCIAL GENERAL LIABILITY	\$1,000,000	NO DEDUCTIBLE
TENANTS LEGAL LIABILITY	\$250,000	NO DEDUCTIBLE

****ABUSE CAN BE SEXUAL, PHYSICAL OR VERBAL ABUSE. THIS COVERAGE WILL REIMBURSE YOU FOR LEGAL EXPENSES IN THE DEFENSE OF ABUSE, PROVIDED YOU ARE PLEADING NOT GUILTY AND FOUND NOT GUILTY.**

1. BASE PREMIUM, excepting Shiatsu & Osteopathy						
PREMIUMS INDICATED ARE ANNUAL PREMIUMS. PLEASE CHOOSE ONLY ONE FROM BELOW						
	\$1,000,000 Limit	\$225.00	+ POLICY FEE	\$25.00	TOTAL	\$250.00
	\$2,000,000 Limit	\$275.00	+ POLICY FEE	\$25.00	TOTAL	\$300.00
BASE PREMIUM, Shiatsu & Osteopathy						
	\$1,000,000 Limit	\$300.00	+ POLICY FEE	\$25.00	TOTAL	\$325.00
	\$2,000,000 Limit	\$350.00	+ POLICY FEE	\$25.00	TOTAL	\$375.00

2. OPTIONAL RETRO-ACTIVE COVERAGE IF YOUR EXISTING POLICY IS A CLAIMS-MADE POLICY, YOU MAY PURCHASE THIS OPTION TO PROVIDE A ONE YEAR EXTENDED REPORTING FOR ANY OUTSTANDING CLAIMS. THIS IS A ONE TIME CHARGE ONLY	ADD \$56.25
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*** I UNDERSTAND THAT BY NOT PURCHASING THE OPTIONAL RETROACTIVE COVERAGE, ANY CLAIMS THAT ARE REPORTED AFTER THE EXPIRY DATE OF MY EXISTING CLAIMS-MADE POLICY, WILL NOT BE COVERED UNDER THIS POLICY AND MAY NOT BE COVERED UNDER MY EXISTING CLAIMS-MADE POLICY

Signature:

Date:

PREMIUM CALCULATION		
1. Base Premium - from 1 Above		\$
2. Optional Retroactive Coverage – if required – from 2 Above		\$
	TOTAL	\$
RESIDENTS OF ONTARIO – add 8% pst	PST	\$
TOTAL PREMIUM PAYABLE		\$

CREDIT CARD PAYMENT – If you wish to pay by credit card, please provide information below (VISA OR M/CARD)
 Credit Card # _____ Expiry Date _____

For Use By Broker			
Checked By		Date	