HOLMAN INSURANCE BROKERS LTD.

3100 Steeles Ave. East, Suite 101,
Markham, Ontario L3R 8T3 Canada
www.holmanins.com www.soepinsurance.ca
Email: service@holmanins.com Tel: (905) 886-5630

Ontario Optometrist Professional Liability Insurance Application Form (Occurrence Basis) C-SEHP Members

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 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.

MEDICAL MALPRACTICE INSURANCE – "Occurrence Basis"
This insurance under Part A, is underwritten on a "occurrence basis".

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

- Limits $2,000,000 per claim / $6,000,000 annual aggregate
- **Occurrence basis**
- Nil Deductible
- Legal Expense coverage with $1,000 deductible
  $5,000 Aggregate Per Certificate period – Expert Witness
  $5,000 Per Claim – Expert Witness
  $5,000 Aggregate Per Certificate period – Legal Consultation
  $5,000 Per Claim – Legal Consultation
  $50,000 Aggregate Per Certificate period – Legal Expenses
  $25,000 Per Claim – Legal Expenses
  $25,000 Therapy and Counselling Expenses (Claims made)
- No charge for non licensed staff (including secretaries) and students under your supervision
- Coverage for writing prescriptions
- Entity coverage at no additional cost for personal service corporations
- Employees covered at no additional cost

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. If the **Applicant** is in any doubt as to whether an individual activity or association is approved for cover under this policy, the **Applicant** must discuss this with Holman Insurance Brokers Ltd.prior to accepting cover hereunder.

Applicant Acknowledgement

Signature _____ Date _____

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 if an Individual — First Name | Initial | Last Name

Full Name of Applicant if a company

If you operate under a personal service corporation, this will automatically cover liability for the corporation, owner and administrative staff (maximum up to 2).

2.a. Address:

Street Address		
City	Province	Postal Code

b Contact numbers. Business Telephone # | Cell #

Email Address: | Fax #

3. Optometrist License Number: _____

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

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

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

Name of Association	Membership No.	Date First Joined	Membership Type
Canadian Society of Eye Health Practitioners (C-SEPH)			

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 specific authorized by the Insurers, and even if the authorization is approved the above premiums may not still apply.**

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

4. Date Of Birth: MM/DD/YY

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

7a. 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.

b. 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 or graduate 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?

c. Do you require liability coverage for any additional Insured's? 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 – c 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? ☐ Yes ☐ No

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

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

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

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

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

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

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

16. Are you aware of any circumstances relating to the questions 10-16 above which may give rise to a potential claim or request for indemnity under this medical malpractice insurance? ☐ Yes ☐ No

17. Have you ever been convicted of any criminal offence, other than motoring, or is any prosecution pending? ☐ Yes ☐ No

NOTE:

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

_____

_____

18. Has any insurer ever cancelled, declined, refused to renew or accepted on special terms your Medical Malpractice Professional Liability Insurance? It **YES**, please give full details: ☐ Yes ☐ No

_____

_____

19. Do you currently purchase Medical Malpractice Professional Liability Insurance? If **YES**, please give full details: ☐ Yes ☐ No

LIMIT:	DEDUCTIBLE	EXPIRY DATE MM/DD/YY	RETRO-DATE: MM/DD/YY	PREMIUM

Premium Calculator and Invoice

OPTOMETRISTS

OPTION A - "Medical Malpractice Insurance "Occurrence Basis"

Limits	Deductible	Annual Premium Optometrists	SELECTED PREMIUM
▼ **Check off one** ***Please select and check off the required limit. Write the applicable premium in the column.*** ▼			
☐ $2,000,000 per Claim / $6,000,000 Aggregate	NIL	$660	
☐ $3,000,000 per Claim / $6,000,000 Aggregate	NIL	$825	
☐ $5,000,000 per Claim / $6,000,000 Aggregate	NIL	$875	
☐ $5,000,000 per Claim / $6,000,000 Aggregate	NIL	$925	

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.a, 7.b, loading applies. **Check off all that apply.**		LOADING	
☐	**Student Status – Question 7.a.**	**ADD 30%**	$
☐	**Teaching - Question 7.b.**	**ADD 50%**	$
		TOTAL PART A	**$**

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

▼ **Check off** ***Please select and check off Write the applicable premium in the column.*** ▼			
Limit	**PD Deductible**	**Annual Premium**	**PREMIUM**
☐ **$2,000,000 per Claim / $2,000,000 Aggregate**	**$500**	**$175**	$
☐ **$5,000,000 per Claim / $5,000,000 Aggregate**	**$500**	**$350**	
☐ **Additional Insured – Question 7.e.**	**$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	**$**

OPTION – C – (OPTIONAL) – Commercial Property Package– "Occurrence Basis"
Package will include business interruption, equipment breakdown, crime, sewer backup and flood.

▼ **Check off** ***Please select and check off one. Write the applicable premium in the column.*** ▼					
Coverage	**Limit**	**Deductible**	**Annual Premium**	**PREMIUM**	
☐ **Equipment and Stock**	**$50,000**	**$500**	**$389**	$	
☐ **Equipment and Stock**	**$100,000**	**$500**	**$461**		
			TOTAL PART A, B and C		**$**
			POLICY FEE		**$ 25.00**
			TAXABLE TOTAL PART A + PART B + C +POLICY FEE		**$**
			For residents of Manitoba add 8% Quebec add 9% Ontario add 8%	**TAX**	**$**
			GRAND TOTAL INCLUDING TAX		**$**

All premiums are annual and 100% retained.
Please retain a copy for your records as no other invoice will be provided.

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.
Rates are subject to change without notice.

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.

EMAIL AUTHORIZATION

In an effort to bring our policy holders the most cost effective insurance plan, all of our correspondence is completed electronically, including renewal applications, invoicing and the delivery of the policy documents. The email address supplied by you in this application will be used. We must be notified of any change to your email address. The policy holder agrees that it will hold Holman Insurance Brokers Ltd. harmless with respect to any e-mail changes caused by the policy holder's failure to provide current and valid information for the receipt of documents.

The Applicant/policy owner further agrees that the policy documents transmitted electronically by Holman Insurance Brokers Ltd. to the electronic address supplied are in lieu of all other forms of communication. The policy Owner accepts that electronic delivery of policy documents is sufficient to meet all reporting requirements of the policy.

The email address supplied may be used to notify you of other related insurance products of interest to you.

DECLARATION

I/we declare that the above statements are true in every respect. I/we hold qualification certificate(s) 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**

Professional and General Liability Checklist

Application completed in full. All questions must be answered.	☐
All pages # 1 to #6 must be returned. (including page #1).	☐
Relevant certificates and qualifications attached.(see question #3)	☐
Membership Documentation (e.g. Certificate of Membership).	☐
Resume cv attached.	☐
Copy of current policy (if you answered "yes" to question #18	☐
Premium calculation – page 5	☐

Method of Payment (must accompany application, instructions next page)

☐ **cheque attached (your cancelled cheque is your receipt)**

☐ **online payment Bank confirmation #_____ Name of Bank _____ confirmation receipt provided by bank provider**

☐ **Visa/Master Card - email confirmation receipt will be sent provider upon transaction**

Please keep a copy your application and payment receipt (ie cheque, Bank confirmation or online payment receipt).

An invoice will not be issued.

PAYMENT OPTIONS

Credit Card

1. Go to https://www.policypayments.com/Holman?step2

Note: There is a administrative fee of 2.50% charged.

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 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