HOLMAN INSURANCE BROKERS LTD.

Holman Insurance Brokers Ltd.
1 Valleywood Drive, Suite #100
Markham, Ontario L3R 5L9
Tel #: 905-886-5630 Toll free: 1-800-567-1279
email: programs@holmanins.com

Optometrists Professional and General Liability Insurance Application Form (Excluding Ontario)

www.holmanins.com
www.soepinsurance.ca

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.

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
- $100,000 Official Proceedings
- $100,000 Sexual Harassment / Abuse
- $25,000 Personal Information Protections and Electronic Document Act Coverage (S.C.,2000, C.5)

COVERAGE PART B – OPTIONAL - COMMERCIAL GENERAL LIABILITY POLICY – "Occurrence Basis"
Commercial 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 under Part B 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. 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 the Coverholder prior to accepting cover hereunder.

Applicant Acknowledgement

Signature _____ Date _____

WARNING – This is a CLAIMS MADE policy.
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 will 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

2.a. Address:

Street Address		
City	Province	Postal Code

b Contact numbers. Business Telephone # Cell #

Email Address: Fax #

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

5. Date Started Practice: MM/DD/YY

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?

☐ Yes ☐ No

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.

Note: Additional Insured

It is requested the following entities are to be added to the policy as Additional Insured, but only with respect to the operation of the Named Insured. The certificate applies to the named insured while operating within the scope of your Professional Services.

Name and complete address, including postal code AND email of Additional Insured:			**Interest in the insurance:**
Name: Email :			☐ Corporate Name ☐ Municipality ☐ Studio ☐ Sponsor ☐ Landlord
Address: (Street)	Province:	Postal Code:	

Name: Email:			☐ Corporate Name ☐ Municipality ☐ Studio ☐ Sponsor ☐ Landlord
Address: (Street)	Province:	Postal Code:	

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

20. Do you sell, manufacture, distribute or wholesale any products?, ☐ Yes ☐ No

If yes, do you sell to others that are not your clients? ☐ Yes ☐ No
If yes, please give full details and describe products.

Professional Services

CATEGORY A

☒ Optometrist

NO CATEGORY APPLICABLE

☐ 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 Holman Insurance Brokers Ltd. for rating.

Premium Calculator

OPTOMETRISTS

COVERAGE – A –" Claims Made" Professional & General Liability				
	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	$725	$
☐	$3,000,000 per Claim / $6,000,000 Aggregate	NIL	$910	
☐	$5,000,000 per Claim / $6,000,000 Aggregate	NIL	$975	

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	$

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**
☐	$2,000,000 per Claim / $2,000,000 Aggregate	$200	
☐	$3,000,000 per Claim / $3,000,000 Aggregate	$300	
☐	$5,000,000 per Claim / $5,000,000 Aggregate	$400	
☐	Additional Insured – Question 7.c.	$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	**$**
	TOTAL PART A + B	**$**
	POLICY FEE	**$ 50.00**
	TAXABLE TOTAL PART A + B POLICY FEE	**$**
For residents of Manitoba add 7% Saskatchewan add 6% Quebec add 9%	**TAX**	**$**
	GRAND TOTAL INCLUDING TAX	**$**

All premiums are annual and 100% retained. Policy is subject to a NIL Deductible.
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.

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.

DISCLOSURE OF MATERIAL FACTS

It is essential that every **Applicant** when seeking a quotation, taking out or renewing an insurance policy reveals to the prospective Insurer(s) any material facts or information (including any material circumstances or change in circumstances) which might influence the judgment of Insurer(s) in determining the premium or in determining whether they will accept the risk. Failure to do so may render the contract of insurance voidable from inception at the option of the Insurer(s) and enable them to repudiate liability there under. If you have any doubt as to what constitutes a material fact or circumstance, seek professional advice.

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
- Advising the **Applicant** of other products or services
- Negotiating, maintaining or renewing insurance on the **Applicant's** behalf
- Providing claims assistance and service.
- 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.

PROGRAM DISCLOSURE

Your coverage will be placed with a program administered by Holman Insurance Brokers Ltd. We haves engaged in a marketing process to offer a competitive product on a group basis with insurers be we have not acted as a broker for any individual participant. Should your application not be accepted for whatever reason by the insurer, the information may be used by Holman to seek an alternative insurer if available.

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

The undersigned Applicant declares on behalf of all parties applying for insurance that to the best of his/her knowledge and belief the statements provided herein are true and complete and all material facts or circumstances have been fully disclosed. The undersigned declares and agrees that the Application together with any other information supplied shall form the basis of any subsequent contract of insurance and undertakes to inform the Insurer of any material alteration to those facts occurring before completion of the contract of insurance.

Applicant 's Signature

Signature _____ Date _____

Print Name _____

Please retain a copy for your records as no other invoice will be provided.

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 #19	☐
Premium calculation – page 6.	☐

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**

Return completed application and additional materials requested to:

Holman Insurance Brokers Ltd.
1 Valleywood Drive, Suite #100, Markham ON L3R 5L9
Telephone:(905)886-5630

Email: programs@holmanins.com

PAYMENT OPTIONS

Credit Card , Visa / Mastercard

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

Note: There is a administrative fee of 2.50% charged, however it does qualify for points and Air Miles.

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.
1 Valleywood Drive, Suite #100
Markham ON L3R 5L9

Please note: NSF Payments – there will be an additional $25 service charge