



CAPPA Canada Liability Program



LMS PROLINK LTD.

480 UNIVERSITY AVE., STE 800, TORONTO, ON, M5G 1V2

SECTION 1: APPLICANT INFORMATION

Please note: All applicants must be members of the CAPPA Canada in order to be eligible for the CAPPA Canada Professional Liability insurance program.

1. Name of Applicant :
2. Are you in good standing with the CAPPA Canada? Yes No. Membership #
3. Address:

	Street Number	Street Name	Apartment / Suite Number
--	---------------	-------------	--------------------------
4. City: Province: Postal Code:
5. Phone: Fax: Email:
6. Website Address :

SECTION 2: UNDERWRITING INFORMATION

1. Please list any professional designations or training certification/accreditation certificates you have completed that relate to the services you are applying for.

Name of Organization	Certifications Obtained	Length of Program

2. a.) Professional service in which you are presently actively participating

 Childbirth educators Lactation educators Labour doulas Antepartum doulas

 Other: Please Specify: _____

Are you involved in Post Partum Doula Services? Yes No.

b) Number of years you have been involved in this/these profession(s):

c) Name of the organization you are involved with for the Professional services:
3. In the past, has the Applicant or any of his/her employees ever been the recipient of any allegations of professional negligence in writing or verbally? Yes No.
4. Is the Applicant or any of his/her employees aware of any facts, circumstances which may reasonably give rise to a claim, other than advised above? Yes No.

If yes, please attach details.

WITHOUT LIMITATION OF ANY SUCH REMEDY AVAILABLE TO THE INSURER, IT IS AGREED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

Please check this box if you are a sole practitioner, not employing any other professionals, who has an incorporated practice and you want to include your corporation as an Additional Named Insured on this policy. Provide the name of your incorporated company below:

SECTION 3: INSURANCE & LOSS HISTORY INFORMATION

1. Do you currently carry any Commercial General Liability or Professional Liability insurance? Yes No

2. If "Yes", please provide details below:

Current Carrier: Premium:

Type of Policy: Policy #: Limit:

Effective Date: Expiry Date:

3. Has any insurer ever declined, cancelled or imposed special conditions for any coverage, for you or your entity in the past? Yes No

If "yes" please give details:

4. Please indicate coverage's required.

Coverage A:

Professional Liability: \$1,000,000 Limit of Liability. Yes No

Please Note: Commercial General Liability may only be elected if Coverage A above is purchased.

Coverage B:

Commercial General Liability: \$1,000,000 Limit of Liability: Yes No

(Coverage A - Professional Liability - must be purchased in order to purchase Coverage B)

Higher Commercial Limits of Liability are available.

Please indicate the limit of liability required: \$ _____

Important Notice to Applicant

This is an application for insurance and the insurer is **not** obligated to accept the applicant for coverage. If a policy is issued, one signed copy of the application will be attached to the policy or certificate. Signature on the application form and submission of a premium payment does not bind the insurer to complete an insurance transaction with the applicant. This policy provides Errors and Omissions insurance that applies on a claims-made basis. The following provides a general description of this coverage and is subject to the terms and provisions of the actual policy.

- A. The policy will not cover any losses from incidents which take place before the Retroactive Date, if any, or after the expiration of the policy period (subject to the Extended Reporting Period provision).
- B. The policy will provide coverage for losses from incidents which take place on or after the Retroactive Date, if any, but before the beginning of the policy period only if the insured did not know of the incident before the beginning of the policy period.
- C. The policy will not cover any loss for which a claim is first made after:
 - 1. The expiration of the policy period or its earlier termination date, if any; or
 - 2. The Extended Reporting Period if any and then only in accordance with the terms described in the policy.
- D. The policy will only cover claims which are first made:
 - 1. During the policy period; or
 - 2. During an Extended Reporting Period if any and then only in accordance with the terms and conditions described in the Extended Reporting Period Section of the policy.
- E. Please request a copy of the Policy and review the terms and conditions to obtain more information.
- F. The limits for Defense Costs are included in the policy limit except where the laws of the province of Quebec apply.

Disclosure and Consent

As part of my application for insurance I consent to the collection and use of personal information required for purposes of considering my application for errors and omissions insurance by the insurer Echelon General Insurance Company and the authorized insurance broker, LMS PROLINK Ltd and LMS PROLINK Group. The insurer and the broker are authorized to collect, use, and disclose personal information and provide such personal information to third parties, as required for the purpose of underwriting this application for insurance, as permitted by the relevant provincial and federal privacy laws or other applicable laws. The privacy policy of Echelon General Insurance can be viewed at the website www.lms.ca and www.echelon-insurance.ca

I understand that at any time I may ask to review the personal information pertaining to my application for insurance and the insurer and broker will be obligated to provide me with any information I am entitled to receive under the relevant provincial and federal privacy laws or other applicable laws.

I have reviewed the information in this Application, gathered information from all partners/directors/ officers/ employees/agents under this entity whether present or prior regarding their knowledge or awareness any error, omission or negligent act in the performance of professional services for others.

The Claim Information Forms, if any, that are attached to this Application include the details of:

- a. All fact situations and incidents which have occurred in the past and which may reasonably be expected to result in a claim, suit or arbitration against the us (the Applicant);

- b. All fact situations and incidents which have occurred in the past and which may reasonably be expected to result in a claim, suit or arbitration against us (the applicant) in the future. All such claims, suits and incidents have been reported to our (Applicants) current or prior insurer(s). It is understood and agreed that all such claims, suits, arbitrations, fact situations and incidents will be excluded from coverage under any policy issued by the Company.

It is understood and agreed that failure to provide true and complete response to any of the questions, statements or request for information in this Application or to provide any other information material to this Application may, at the sole option of the Company, result in the voiding of the insurance policy issued in reliance on this Application and /or denial of coverage for specific claims asserted against us (the Applicant) or any other insured under the policy. The undersigned on behalf of Applicant and all other insured under any this policy issued by the Company, hereby waives any defence to an action by the Company for recession of such policy based upon misrepresentation of fact or failure to disclose material information in connection with this Application. Applicant agrees to hold the Company harmless from all loss as a result of any such misrepresentation or failure to disclose, including, without limitation, all costs and attorney fees incurred by the Company in connection with said action for rescission.

I HEREBY DECLARE that the above statements and particulars are true to the best of my knowledge, that I have not suppressed or misstated any facts and I agree that this application shall form part of the insurance policy. I also acknowledge that I am obligated to report any changes that could affect the disclosures in this application that occur after the date of signature, but prior to the effective date of coverage.

Applicant's Signature: _____

Name (please print): _____

Date: _____

Premium Calculation(s):

Coverage A: Professional Liability: \$1,000,000		
Postpartum Doula	\$300.00	\$ _____
All other Practitioners	\$250.00	\$ _____
Coverage B: Commercial General Liability: \$1,000,000		
Each Practitioner	\$100.00	\$ _____
(Must Purchase Coverage A above to purchase Coverage B)		
If policy is to be effective:		
Between March 1 – May 31	= Premium charged is 100% of premium	\$ _____
Between June 1 – Aug 31	= Premium charged is 75% of premium	\$ _____
Between Sept 01 – Nov 30	= Premium charged is 50% of premium	\$ _____
Between Dec 01- Feb 28	= Premium charged is 25% of premium	\$ _____
Sub-Total		\$ _____
Policy fee		\$ \$50.00
Tax: Ontario only 8%		\$ _____
Total Payable:		\$ _____

Please make Cheques Payable to : LMS PROLINK Ltd. *Payment must be received prior to binding.*

Please return this application to Marie Pinack by one of the following methods:

- By Fax to 416-595-1649 attn: Marie
- By Email to Mariep@lms.ca
- By Mail : LMS PROLINK Ltd. Attn: Marie Pinack
480 University Av., #800, Toronto, ON M5G 1V2