Lackner McLennan Insurance
423 King Street North, Waterloo, ON N2J 2Z5
1-800-265-2625 Ext. 350 • Fax: 519-579-1151
beth@iNeedaPolicy.com

COMPLEMENTARY HEALTH CARE PRACTITIONERS

Application for Professional & General Liability

This Application is for an Occurrence Form Policy

Please return the completed documents by fax, email or mail. Thank You.

CANADIAN BROKER • CANADIAN INSURER • CANADIAN COMMUNITY

Exclusive to
Canadian Association of Natural Nutritional Practitioners

ALL QUESTIONS MUST BE ANSWERED COMPLETELY. INDICATE "N/A" IF A QUESTION IS NOT APPLICABLE. IF THE SPACE PROVIDED IS INSUFFICIENT TO ANSWER A QUESTION FULLY, PLEASE ATTACH A SEPARATE SHEET.

APPLICANT NAME: _____

MAILING ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ CELL: _____ EMAIL: _____

Please check the area(s) of complementary healthcare you are qualified to practice. If the modality is not shown, check ***other and explain below.
We also insure more than 365 other modalities. Visit www.iNeedaPolicy.com for the list.

NUTRITIONAL CONSULTING		CrossFit Certified		Iridology		Reflexology	
Acupressure		Crystal Healing		Kinesiology **		Reiki	
Aromatherapy		Energy Work		Metabolic Balance		Shiatsu **	
Biofeedback		Esthetics *		Osteopathy **		Thai Yoga Massage	
Bowen Therapy		Healing Touch		Personal Trainer		Therapeutic Touch	
Chair Massage		Hydrotherapy		Qi-Gong		Yoga/Pilates	
Cranial Sacral		Ionization/Detox		Raindrop Therapy		Other Modalities ***	

*If you have chosen Esthetics above, please list the services you provide.	
**Additional premiums may apply. Please call us today, toll free 1-800-265-2625 x 336.	
***Please provide details for other modalities not shown above in this space.	

This is an Annual Policy.

Standard PREMIUM		
$5,000,000 Limit	$200.00	Includes $25 fee and 25% commission

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

Do you consult with clients via the internet (website, social media), international phone consultation, skype or face time? Yes ____ No ____
If yes, you need **International Web Based Consulting/Teaching** coverage offered for a $5,000,000 limit, for these consultations ONLY.
Please add $50.00 to the selected base premium.

OUR POLICY COVERAGE IS CANADAWIDE ONLY. Temporary International Coverage Can Be Arranged.

PREVIOUS COMPLEMENTARY HEALTHCARE INSURANCE INFORMATION (Professional, Malpractice or PLI Insurance)				
Insurance Company	Policy Coverage Limit	Policy Period	POLICY TYPE -Occurrence Form OR Claims Made	If unsure, check your current policy.

1. Has complementary healthcare insurance ever been declined, cancelled or renewal thereof been refused by the Insurer? Yes ____ No ____

2. Have you had any losses in the past three years? Yes ____ No ____

3. Do you have knowledge of any circumstance which could result in a claim or lawsuit being brought against you? Yes ____ No ____

IF YOU ANSWERED YES TO ANY OF THE ABOVE 3 QUESTIONS, PLEASE PROVIDE INFORMATION ON A SEPARATE SHEET AND ATTACH IT TO THIS APPLICATION. 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.

Do you offer cooking classes or catering? Yes ____ No ____

Are you an active member of the CANNP? Yes ____ No ____

REGISTRATION #: _____

EFFECTIVE DATE OF COVERAGE

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

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. I authorize Lackner McLennan Insurance Ltd. to communicate directly with the member association.

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 X _____ **Date X** _____

COVERAGE LIMITS - THIS IS AN OCCURRENCE FORM POLICY		
PROFESSIONAL LIABILITY	$5,000,000	NO DEDUCTIBLE
LEGAL EXPENSE FOR ABUSE**	$25,000	NO DEDUCTIBLE
CRIMINAL EXPENSE COVERAGE INCLUDED**	$10,000	NO DEDUCTIBLE
COMMERCIAL GENERAL LIABILITY	$5,000,000	NO DEDUCTIBLE
TENANTS LEGAL LIABILITY	$500,000	NO DEDUCTIBLE
OFFICE PROTECTION including LOSS OF REVENUE	$10,000	$500.00 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.**

2. OPTIONAL RETROACTIVE COVERAGE. Please Read and Sign Below. ***For more information, visit*** **www.iNeedaPolicy.com** IF YOUR EXISTING POLICY IS A CLAIMS-MADE POLICY, YOU MAY PURCHASE THIS OPTION TO PROVIDE A ONE-YEAR EXTENDED REPORTING PERIOD FOR ANY OUTSTANDING CLAIMS. THIS IS A ONE TIME CHARGE ONLY.	**ADD 25%** of above premium

***** 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 X _____ **Date X** _____

PREMIUM CALCULATION		
1. Base Premium - from Premium Chart		$
2. Optional Retroactive Coverage – if required – from 2 Above		$
3. International Web Based Consulting/Teaching Coverage	**IF REQUIRED ADD $50**	$
	TOTAL	$
RESIDENTS OF ONTARIO or MANITOBA – add 8% PST	**PST**	$
TOTAL PREMIUM PAYABLE		$

CREDIT CARD PAYMENT – If you wish to pay by VISA OR MASTER CARD, please provide information below:

Credit Card # **Expiry Date**

Signature of Cardholder