# B.C ASSOCIATION OF CLINICAL COUNSELLORS

MAIL APPLICATION TO: THE MITCHELL & ABBOTT GROUP - 2000 GARTH ST., SUITE 101, HAMILTON, ON, L9B OC1

## Business Insurance Program: April 1, 2019 – 2020 Application

### GENERAL INFORMATION

| | | |
|---|---|---|
| Name of Applicant | | Telephone Number<br>( ) |
| Business Name - *Legal Entity<br>***Please Note Below** | | E-Mail |
| Street Address | | |
| City | Province | Postal Code |
| Mailing Address (*if different from Business Address*) | | |
| Are you a BCACC member "in good standing"? ☐ Yes ☐ No | | Membership Number |
| Class of Membership:<br>☐ Registered ☐ Inactive ☐ Retired ☐ Student | | Date of Retirement/Inactivity (mm/dd/yyyy) |

- List other counseling therapies/modalities (i.e. music, art, yoga, equine, canine etc.) & percentage of total services? _____
- Does your work as a counselor involve any "adventure" counseling activities? ☐ Yes ☐ No
- ***Do you have any employees? ☐ Yes ☐ No # Professionals/ Counsellors _____ # Clerical / Administration _____**

(a) In the past 5 years, has the Applicant or any of his/her employees ever been the recipient of any allegations, in writing or verbally, of professional negligence which has not previously disclosed? ☐ Yes ☐ No If yes, please attach details.

(b) Is the Applicant or any of his/her employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? ☐ Yes ☐ No If yes, please attach details.

(c) Has any policy or application for errors & omissions insurance been cancelled, declined or refused within the last 5 years? ☐ Yes ☐ No If yes, please attach details.

WITHOUT LIMITATION OF ANY OTHER 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 EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

### TO ENROLL

Select the required Limit of Insurance for your coverage needs. Return completed, signed application form with payment to The Mitchell & Abbott Group. Coverage will be affected upon approval of application and receipt of payment in the amount of the total premium.

Desired Effective Date of Coverage (mm/dd/yyyy) - Coverage may be delayed until after your application has been approved by The Mitchell & Abbott Group. _____

***PLEASE NOTE: Legal Entity:**
***Coverage provided includes up to 3 professionals. Additional options available.***
**In the event of a claim, both the Professional and the Business Name could be named in a statement of claim or lawsuit. Legal Entity Coverage protects the clinic and its assets in such circumstances.**
**This coverage is applicable if you are a business owner and employ or subcontract other counsellors.**

## ❖ PROFESSIONAL LIABILITY: (Premiums Include a $20 Administration Fee)

*Select premium from the required Limit of Insurance*

| Limit of Insurance Per Claim | Aggregate Limit Per Policy Period | Annual Premium | Total |
|---|---|---|---|
| $2,000,000. | $2,000,000. | $105 | |
| $5,000,000. | $5,000,000. | $155 | |

## ❖ ADDITIONAL OPTIONS for Legal Entity Coverage: (Premiums Include a $20 Administration Fee)

*Select premium from the required Limit of Insurance*

| Limit of Insurance Per Claim | Aggregate Limit Per Policy Period | Annual Premium | Total |
|---|---|---|---|
| **4 to 10 Professionals/Employees:** | | | |
| $2,000,000. | $2,000,000. | $175 | |
| $5,000,000. | $5,000,000. | $275 | |
| | | | |
| **11 to 20 Professionals/Employees:** | | | |
| $2,000,000. | $2,000,000 | $245 | |
| $5,000,000 | $5,000,000 | $395 | |
| | | | |
| **Over 21 Professionals/Employees:** | | | |
| $2,000,000 | $2,000,000 | Available upon request | |
| $5,000,000 | $5,000,000 | Available upon request | |

**INACTIVE MEMBERS: Discount the above premiums by 60% the 1st year of Inactivity; 70% in the 2nd year; and 80% the 3rd year & there after**

**RETIRED MEMBERS: 7 years post-retirement coverage included in above premiums**

COMMENTS: (i.e. Additional Insured – full name and address)

## ❖ COMMERCIAL GENERAL LIABILITY: (Premiums Include a $10 Administration Fee)

*Select premium from the required Limit of Insurance*

| Limit Of Insurance Per Occurrence | Aggregate Limit Per Policy Period | Annual Premium | Total |
|---|---|---|---|
| $2,000,000. | $2,000,000. | $75 | |
| $5,000,000. | $5,000,000. | $95 | |

## ❖ ADDITIONAL OPTIONS for Legal Entity Coverage: (Premiums include a $10 Administration Fee)

*Select premium from the required Limit of Insurance*

| Limit of Insurance Per Claim | Aggregate Limit Per Policy Period | Annual Premium | Total |
|---|---|---|---|
| **4 to 10 Professionals/Employees:** | | | |
| $2,000,000. | $2,000,000. | $140 | |
| $5,000,000. | $5,000,000. | $180 | |
| | | | |
| **11 to 20 Professionals/Employees:** | | | |
| $2,000,000. | $2,000,000 | $205 | |
| $5,000,000 | $5,000,000 | $265 | |
| | | | |
| **Over 21 Professionals/Employees:** | | | |
| $2,000,000 | $2,000,000 | Available upon request | |
| $5,000,000 | $5,000,000 | Available upon request | |

## ❖ BUSINESS CONTENTS:

*Select premium from the required Limit of Insurance (higher limits available)*

| Limit Of Insurance Per Occurrence | Annual Premium | Total |
|---|---|---|
| $25,000. | $275 | |
| $50,000. | $325 | |

## ❖ ACCIDENTAL DEATH & DISMEMBERMENT:

| Limit Of Insurance Per Occurrence | Annual Premium | Total |
|---|---|---|
| $25,000. | $15 | |

## ❖ NAME OF BENEFICIARY:

**TOTAL PREMIUM** *(all coverages selected)* $ _____

**APPLICANT'S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM**

I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to ENCON Group Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize ENCON Group Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on ENCON's privacy policy, please contact privacy-officer@encon.ca.

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**DECLARATIONS AND SIGNATURE**

The undersigned Applicant for this insurance declares that, to the best of his/her knowledge and belief, the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned further agrees that if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy. It is also agreed that should a policy be issued, it is understood that eligibility for this program is contingent upon membership in good standing in the B.C. Association of Clinical Counsellors.

Signature of Applicant _____ Date _____

PAYMENT OPTIONS:

| | |
|---|---|
| CHEQUE ☐ VISA ☐ MASTERCARD ☐ | PAYMENT ENCLOSED ☐ |
| CARD NUMBER | EXPIRY DATE |
| CARDHOLDER NAME | |

**PLAN ADMINISTRATOR:**
**The Mitchell & Abbott Group Insurance Brokers Limited**

- **Phone: 905-385-6383**
- **Toll Free: 1-800-463-5208**
- **Fax: 905-385-7905**

**E-mail: bmathieson@mitchellabbottgrp.com**