CUPPING THERAPISTS

PROFESSIONAL LIABILITY INSURANCE APPLICATION

THIS IS AN APPLICATION FOR A CLAIMS MADE PROFESSIONAL LIABILITY POLICY WITH CLAIM EXPENSES INCLUDED IN THE LIMIT OF LIABILITY. All questions must be answered completely. If there is no answer, write "none" or "n/a" in the space provided. Where space provided is insufficient to fully answer, please use and attach separate sheet(s).

1. (a) Name of Applicant: _____

   (b) Mailing Address: _____
   Street City

   _____
   Province Postal Code

   _____
   E-mail Address

*This insurance program is for **individuals** only. If you own or operate a clinic or business, please contact BFL Canada to make separate coverage arrangements for your business.*

2. (a) Are you a member of any professional or industry association, or regulatory body? Yes ☐ No ☐

   Confirm the name of the organization: _____

   Provide your membership no.: _____

   (b) Have you successfully completed a recognized cupping therapy training program? Yes ☐ No ☐

   If Yes, provide the following information:

   Confirm the name of the course and educational institution that you attended:

   Program/Course of Study: _____

   Institution/College: _____

   Number of hours of training: _____

   Date of Graduation/Completion: _____

Note: Please ensure that you have copies of your education and credentials. You may be required to provide this information to the insurer.

3. (a) Coverage is provided for the following cupping techniques **only**.

   Indicate which technique(s) you are seeking coverage for:

   Fire Cupping Yes ☐ No ☐

   Suction / Vacuum Cupping Yes ☐ No ☐

   Silicone Cupping Yes ☐ No ☐

   Note: this insurance program does not provide any coverage for Wet Cupping nor cupping that involves any incisions or bleeding.

   (b) Do you provide other services or modalities, in addition to Cupping Therapy? Yes ☐ No ☐

   If Yes, provide the following detail:

Type of Service/Modality	Percentage of Annual Revenue
	%
	%
	%

   (c) Do you wish to purchase coverage for the additional modalities listed above? Yes ☐ No ☐

   If Yes, there will be a separate quote provided to you and an additional premium charge.

4. Select one of the following coverage options to purchase:

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Option	**Professional Liability Insurance**	**Deductible**	**Annual Premium**
☐	$1,000,000 per claim / $1,000,000 Aggregate	$500	$300.00
☐	$2,000,000 per claim / $2,000,000 Aggregate	$500	$425.00
All premiums are 100% retained and non-refundable			
		Sub-total:	$_____
		Add applicable Provincial Sales Tax	$_____
		Total Amount Due:	**$_____**
Please note that the amounts shown above do not include any other modalities. Premiums for other modalities will be underwritten and priced separately.			

5. Have you ever been subject to disciplinary action by, or suspended from practice by, any governing body of your profession or your employer? Yes ☐ No ☐

   If Yes, explain: _____

6. Have you ever had a claim made against you arising out of health-related services? Yes ☐ No ☐

   If Yes, please provide the following details on a separate sheet:

   (a) Date of Claim (b) Claimant's Name (c) Nature of Claim (d) Current Status of Claim

THE APPLICANT DOES HEREBY PROVIDE THE FOLLOWING WARRANTY TO THE INSURER

7. Does the Applicant, any of the Applicant's employees or any other person proposed for this insurance have knowledge or information of any fact, circumstance or situation which could reasonably give rise to a claim which would fall within the scope of the proposed insurance? Yes ☐ No ☐

   If Yes, provide details: _____

   _____

   It is understood and agreed that if knowledge of any such facts, circumstances or situations exists, whether or not disclosed, any claim or action subsequently arising or developing therefrom shall be excluded from coverage under any policy issued by Trisura Guarantee Insurance Company.

PLEASE NOTE: COVERAGE CANNOT BE BOUND UNLESS THIS APPLICATION HAS BEEN FULLY COMPLETED AND DULY SIGNED AND DATED, AND THE APPLICABLE INSURANCE PREMIUM AND TAXES (IF APPLICABLE) HAVE BEEN PAID IN FULL.

Applicant	Date
Signature	Title

CREDIT CARD AUTHORIZATION (VISA or MASTERCARD ONLY)	
( ) Cardholder hereby authorizes BFL CANADA Risk & Insurance Services Inc. to withdraw funds from the credit card stated below for the payment of insurance coverage.	
Please check one: ( ) VISA ( ) MASTERCARD	Card Number:
Expiry Date: (MM/YY): _____ /	Amount: $
Cardholders First Name:	Cardholders Last Name:
Applications can be emailed or faxed along with the credit card authorization to the following address: **BFL CANADA Risk & Insurance Services Inc.** **181 University Avenue, Suite 1700** **Toronto, Ontario, M5H 3M7** **Telephone: 1-(800) 668-5901** **Fax: (416) 599-5458** **Email: ccosme@bflcanada.ca or kgaetano@bflcanada.ca**	