



Empower Results®

# Insurance Application for Professional and Commercial General Liability Coverage

For members of Association of Cooperative Counselling Therapists of Canada

Français disponible sur demande.

Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal code: \_\_\_\_\_

Business/corporation name (if you are the owner): \_\_\_\_\_

Coverage under this policy will extend automatically to your business, but only if you are sole proprietor with no employees.

Business address : \_\_\_\_\_

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal code: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

Email address: \_\_\_\_\_

ACCT membership no. (Note: coverage under this policy is only available for ACCT members.) \_\_\_\_\_

## Please select one of the following options:

Canadian counsellors who hold the Master Therapeutic Counsellor designation, Masters degree or Ph.D. in Counselling or related field

Canadian counsellors who do not yet hold the Master Therapeutic Counsellor designation

1. **Have you ever sustained a professional liability or general liability loss or have claim(s) been made against you in the past?**  Yes  No

If yes, please explain in detail.

2. **Have you any knowledge of any negligent act, error or omission and or breach of duty, which may give rise to a claim against you?**  Yes  No

If yes, please explain in detail.

3. **Has any application for professional liability or commercial liability coverage ever been denied?**  Yes  No

4. **Do you have any other business or profession, other than your professional practice?**  Yes  No

If yes, please explain in detail.

5. **Do you provide services or perform activities outside of Canada?**  Yes  No

If yes, please attach details, indicating country and percentage of time spend outside of Canada

6. **For business owners:**  Yes  No

Do you have any employees?  Yes  No, I am sole proprietor

If yes, how many (including yourself) \_\_\_\_\_

If you have employees, we can offer quote for the legal entity coverage at an additional premium.

If you answered "Yes" to Questions 1 to 6, please contact an Aon licensed insurance representative at **1.877.766.3098**.

7. **What is your educational background?** Please indicate your educational level and area of specialization.

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8. **How long have you practiced as a counsellor?** \_\_\_\_\_

9. **Please provide a brief description of your operations and services provided, including types of mental health issues that you specialize in.**

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10. **Do you refer patients to psychiatric institutions?**  Yes  No

If yes, under which circumstances?

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11. **Please provide your total gross revenue:** \$ \_\_\_\_\_

12. **Complete the following for any person performing professional activities under your business:**

(We may request the resumes of each.)

Name	Duties	Professional designation	Years of experience

13. **Please respond to this question **only** if you apply for coverage through the ACCT program for the first time:**

Do you have current professional liability coverage in place?  Yes  No

If yes, give particulars of all professional liability insurance held by you (the applicant) for the past three (3) years.

Type of policy		Policy number	Insurer	Policy limit	Policy period
Claims made	Occurrence				
<input type="checkbox"/> *	<input type="checkbox"/>				
<input type="checkbox"/> *	<input type="checkbox"/>				
<input type="checkbox"/> *	<input type="checkbox"/>				
<input type="checkbox"/> *	<input type="checkbox"/>				
<input type="checkbox"/> *	<input type="checkbox"/>				

\*Indicate if you have a retroactive date: (day/month/year)

## Coverages available

Please indicate your choice as per the rating chart below. All premiums are fully earned and retained.

Limit (per claim)	Aggregate (per term)	Professional liability (Mandatory coverage)	Professional liability and commercial general liability**
		Premium	Premium
<b>Category A:</b>			
All Canadian counsellors who are <b>members of ACCT</b> and hold the Master Therapeutic Counsellor designation, Masters degree or Ph.D. in counselling or related field.			
\$1,000,000	\$1,000,000	\$80 <input type="checkbox"/>	\$115 <input type="checkbox"/>
\$2,000,000	\$2,000,000	\$100 <input type="checkbox"/>	\$140 <input type="checkbox"/>
\$5,000,000	\$5,000,000	\$165 <input type="checkbox"/>	\$235 <input type="checkbox"/>
<b>Category B</b>			
All Canadian counsellors who are <b>members of ACCT</b> and do not yet hold the Master Therapeutic counsellor designation			
\$1,000,000	\$1,000,000	\$88 <input type="checkbox"/>	\$127 <input type="checkbox"/>
\$2,000,000	\$2,000,000	\$110 <input type="checkbox"/>	\$154 <input type="checkbox"/>
\$5,000,000	\$5,000,000	\$182 <input type="checkbox"/>	\$259 <input type="checkbox"/>

\*\* Commercial General Liability is recommended to all practitioners to cover any third party bodily injury or property damage caused due to their operations (such as to those who contract out their services or bill under a separate entity)

## Payment information

The following provinces are subject to provincial sales tax:

Ontario residents add 8% sales tax  
Québec residents add 9% sales tax  
Manitoba residents add 8% sales tax

All other provinces are exempt. GST is not applicable to insurance premiums.

All cheques payable to Aon Reed Stenhouse Inc., or complete credit card authorization below. Credit card information may be forwarded to our office by the following methods: fax, email or by mail.

Sub-total	\$
Tax	\$
Total enclosed	\$

## Authorization for credit card charge

VISA or M/C account no.: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Cardholder name: \_\_\_\_\_ Signature: \_\_\_\_\_

Please mail, fax or email all completed applications to the appropriate address or number shown below.

## Aon Risk Solutions

Dept. 700200, P.O. Box 3309, MIP, Markham, ON L3R 6G6  
Fax: 1.877.766.9075 | Tel.: 1.877.766.3098  
Email: aha@aon.ca

## Declarations, warranty, privacy and consent

The Applicant(s) (collectively, the "Applicant") confirms that he/she wishes to use Aon's services and consents to Aon's collection, use and disclosure of any personal information required for the following purposes:

- To determine eligibility and process applications for insurance products and to provide information and services as requested
- To understand and assess ongoing needs and offer products and services to meet those needs
- For communication, service, billing and administration purposes
- For claims administration and data analysis
- To comply with legal, audit, security and regulatory requirements
- To verify the personal information provided.

The Applicant authorizes Aon to collect and/or disclose the Applicant's personal information from/to third parties such as insurance companies, other brokers, adjusters, agencies, motor vehicle/driver licensing authorities and others as may be required for the above purposes. If the Applicant is providing any additional insured personal information, the Applicant warrants having obtained the prior written consent from each additional insured for the collection, use and disclosure of their personal information as set out herein. The client acknowledges that in providing the requested services, Aon may need to utilize its affiliates and/or third service providers who may be located inside or outside of Canada and therefore personal information may be subject to the laws of that jurisdiction. The Applicant acknowledges that he/she may withdraw a previously given consent for one or more purposes at any time, by contacting Aon's Privacy Officer in writing and understands that such withdrawal may result in Aon's inability to provide the services requested. The Applicant acknowledges that this Consent remains in force until withdrawn by the Applicant in whole or in part, regardless of any other consents the Applicant may sign authorizing the collection, use or disclosure of personal information. Aon's Privacy Policy and Privacy Officer contact information is available at <http://www.aon.com/canada/about-aon/privacy.jsp> or by calling any Aon office in Canada.

Print name of applicant: \_\_\_\_\_ Position: \_\_\_\_\_

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: Coverage cannot be bound unless this application has been fully completed, duly signed and dated.**