

Insurance Program

Program Application



Basic Information

Broker:	Mitchell & Abbott Group Insurance Brokers Ltd.
Office No:	56307
Business Name of Applicant:	
Full Name of Principal(s):	
Service Location/Risk Address (including Postal Code):	
Mailing Address (if different than service location):	
Contact Name/Principal(s):	
Telephone:	
No. of years in business:	
Previous Insurer:	
Policy No.:	
Exp. Date:	
Previous Insurance Declined or Cancelled?:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, full details: _____
Any claims in the last 5 years?:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide full details including date, type of loss, amount paid and outstanding: _____

Mortgage/Additional Named Insured/Landlord – Include Loss Payee Name and Address (including Postal Code):
1. Ministry of Government & Customer Services – 20 Dundas Street, 4 th Floor, Toronto, ON, M5G 2C2
2.
3.

Location Details - Building

Please select all that apply at this location

- Single Building Leased Multi-Unit Building/Strip Mall Enclosed Shopping Mall
 Single Building Owned – (if owned additional building details will be requested by the broker)
 Other (describe):

Total Square Footage Occupied by Applicant: _____

Is the building Sprinklered?

- Yes No If Yes, what percentage is sprinklered? _____%

Initial here: _____

Physical Protection

Fire Alarm:	<input type="checkbox"/> None	<input type="checkbox"/> Local	<input type="checkbox"/> Monitored
Burglar Alarm:	<input type="checkbox"/> None	<input type="checkbox"/> Local	<input type="checkbox"/> Monitored

Operational Details

Annual Gross Revenue/Commissions:	\$
Number of Employees:	
Full Time:	
Part Time:	
Owners/Managers:	
Number of Terminals:	

Professional Liability Details

Applicant is an:

- Individual
 Partnership
 Corporation
 Other:

Has Applicant operated under a different corporate name in the past?

- Yes
 No
 If yes, please provide details: _____

Are your operations controlled, owned, or associated with any other firm, corporation, or company?

- Yes
 No
 If yes, please provide details: _____

Explain the educational requirements for your profession/employees: _____

Has the Applicant ever been investigated by, or suspended from practice by the governing body for his/her profession?

- Yes
 No
 If yes, please provide details: _____

Provide details of all Errors and Omissions Insurance carried over the past three years if any:

Insurer:	Policy #:	Period:	Limit:
Insurer:	Policy #:	Period:	Limit:
Insurer:	Policy #:	Period:	Limit:

Has the Applicant had similar insurance declined, cancelled, or refused the past five years?

- Yes
 No
 If Yes, please provide details: _____

During the past five years has the Applicant, partners, principals or employees had one or more claims because of failure to render professional services, or are the Applicant, partners, principals, or employees aware of any facts, circumstances or allegations which may give rise to a claim?

- Yes
 No
 If Yes, please provide details: _____

Initial here: _____

Additional Comments/Information Remarks

Please provide any additional comments/information:



Date Coverage Required:	
Signature of Applicant:	
Print Name:	
Title/Position:	
Email:	

If you would like to receive notices and correspondence by email, please include your email above.