



THE CG&B GROUP INC.
Dental Lab Program Application

Date:

Lab Name			
Owners Name			
Mailing Address			
Contact		Phone #	
Website		Fax #	
Email		Cell #	
Description of Operations and Products / Services (Details of activities for each named insured)			
In Business Since:		Past Experience:	
Total Revenue: \$			
Are all employees covered under WSIB? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, who is not covered?			

Current Insurer		
Company Name	Expiry Date	Premium
Current year -		\$

Employee Dishonesty	
Number of Class A employees? (excluding owners)	

Business Interruption (Profits)	
Any key machine or process?	
Time delay following a loss?	
Is ordinary payroll required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of days: Limit\$

CGL	
Any Sub-Contractors used? If so, please provide full details and cost of sublet work: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are certificates of insurance requested annually? <input type="checkbox"/> Yes <input type="checkbox"/> No	

	Supervising RDT's	Technologists	Other Salaried Staff	Total
Number of Employees				
Any employees under contract? <input type="checkbox"/> Yes <input type="checkbox"/> No				
How long have these procedures been in effect?				
Have all employees been screened? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are employees left alone with client(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<i>If yes, please explain:</i>				



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Do you have a formal written policy for your employees relating to their relationships with their client(s), including physical, sexual and mental abuse? Yes No

Are the abuse policies communicated to the employees? Yes No

What are your procedures for handling allegations or complaints made about your employees?

Have any allegations of abuse been made against you, your employees, or any other person associated with your organization during the past 10 years? Yes No

If yes, give full details on a separate sheet including whether such allegations were made to any Governmental Authority, including the police.

Give details of all incidents and/or claims arising from abuse made against you, your employees, or any other person associated with your organization during the past 10 years:

Professional Liability

Do you own or control any subsidiaries? Yes No
If yes, please provide full details

Do you perform any dental lab technician services outside Ontario? Yes No (if yes, describe)

Professional Liability - Continued

Are the supervising Registered Dental Technologists employed at your lab members of the Association of Dental Technologists of Ontario? Yes No

Has the applicant or any of its employees ever been investigated by, or suspended from practice by, any body governing the practice of this profession or any other body e.g. a court? If "Yes", please provide details: Yes No

Are you aware of any facts or circumstances, which may give rise to a claim under your professional liability insurance purchased through your membership association? Yes No

Does the applicant have set procedures for who specifically is authorized to work with patients if they are sent to the laboratory for services such as shading or other related services? If yes, please describe below: Yes No

Do you have a dentists' chair on-site in the event that a dental patient is sent to your lab for special services such as shading? Yes No

Do you employ a dentist at your laboratory? Yes No

Claims in the Past 3 Years?

Date of Loss	Type	Description	At Fault?	Payment

Has an Insurance Company ever cancelled your insurance? Yes No



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Signature Section:

I/We declare that the statements made herein are in every respect true and correct and hereby apply for contract of insurance to be based upon the truth of the said statements.

Signed by: _____ Date _____

Position: _____

Broker _____

Signing of this form does not bind the Applicant to complete the Insurance.