Healthcare Renewal Application

SIGNAL UNDERWRITING

Please complete this application in its entirety, as the responses given are material to the provision of terms. There is space for more details in the Additional Information Section at the end of the application. Coverage(s) may be provided on a claims-made basis.

Named Insured: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Contact: _____ Email: _____ Phone: _____

Section 1: About Your Organization

1. Have your operations changed from what was reported previously? If yes, please provide details.* Yes O No O
2. Do you expect a material change in your operations in the next 12 months? If yes, please provide details.* Yes O No O
3. Have any of your best practices or risk management protocols changed? If yes, please provide details.* Yes O No O
4. Did you organization receive accreditation last year? Yes O No O
5. Please provide the annual number of client, clinic, or lab visits: _____

Section 2: Staffing

1. Please indicate the number of your salaried staff by Full Time Equivalent (FTE) **(1 FTE = 37.5 hours/week)**:

	Advanced Care Flight Paramedics		Medical Lab Technicians		Primary Care Paramedics
	Advanced Care Paramedics		Medical Radiation Technicians		Prosthetists/Orthotists
	Acupuncturists		Midwives		Psychologists
	Audiologists/Speech Language		Music Therapists		Recreation/Activation Therapists
	Case Managers		Naturopaths		Registered Massage Therapists
	Case Workers		Nurse Practitioners		Registered Nurses
	Chiropodists/Podiatrists		Nursing Assistants/Nurse Aides		Registered Practical Nurses
	Chiropractors		Occupational Therapists		Registered Psychiatric Nurses
	Counsellors/Mental Health Workers		Opticians		Respiratory Therapists
	Critical Care Flight Paramedics		Optometrists		Social Workers
	Dentists		Osteopaths		Sonographers
	Dental Assistants/Hygienists		Personal Support Workers		Administration, Food Services,
	Dieticians/Nutritionists		Pharmacists		Housekeeping, Maintenance,
	Doulas		Pharmacist Techs/Assistants		Management, etc.
	First Surgical Assistants		Physicians in an Administrative Role		Other, please specify below:
	Homeopaths		Physicians in a Clinical Role		
	Kinesiologists		Physician Assistants		
	Licensed Practical Nurses		Physiotherapists		

2. Please indicate the number of independent contracted professionals and their professions:

#	*Professional Description*				

3. Please indicate the number of physicians practicing at your facility and their specialty:

	Anesthesiologists		Cosmetic Surgeons		General Practitioners
	Obstetrician-Gynecologists		Psychiatrists		Radiologists
	Surgeons				

*Please provide further details in the space provided under the Additional Information Section.

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Section 3: Beds

Please indicate the number of beds you are licensed for:

	Chronic Care/Complex Continuing Care		Hospice Care		Respite Care
	Group Home – Developmentally Delayed		Men's Shelter		Surgical
	Group Home – Mental Health		Non-Senior Assisted Living		Transitional Housing
	Group Home – Addiction/Recovery		Palliative Care		Women's/Family Shelter
	Homeless Shelter		Residential Addiction/Recovery		Other - please specify below:
			Residential Mental Health		

Privacy Policy

By signing this form, you are consenting to the collection, use, disclosure, and retention of your personal information for the purposes of underwriting and rating, policy issuance, processing and remitting premium, reporting claims, complying with applicable laws and governing bodies, reporting and monitoring results and fraud and criminal prevention. Please see www.signalunderwriting.com/privacy-statement for our External Privacy Policy.

Declarations

I/We, the undersigned, do declare and warrant that all statements and responses provided in this application and the attached addenda are to the best of my/our knowledge are true. Further, I/we warrant that no information has been withheld, suppressed or misstated any material facts that the underwriters may come to rely upon. I/We will notify the underwriters as soon as practicable if anything material is to change. I/We hereby agree and accept that this Declaration shall be the basis of such contract and will form part of the policy. Signing this application does not bind the underwriters or insurers to complete the insurance, nor does it bind the me/us to purchase the quoted coverage.

For British Columbia residents: Signal Underwriting Inc. operates as Signal Underwriting Services in British Columbia.

For Quebec and New Brunswick residents: Signing this Declaration confirms your request that all documentation and correspondence pertaining to the insurance coverage be in the English language.

Name (please print)	Title	Date

Signature

Additional Information Section

Please use this space to provide any additional information from the questions above, from the addenda or anything you feel is material to your operations:

*Please provide further details in the space provided under the Additional Information Section.

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