Residential Senior Care Application

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. What year was your organization established: _____
2. Is your organization incorporated? Yes ☐ No ☐
3. Are you registered as a Not-For-Profit? Yes ☐ No ☐
4. Do you conduct fundraising activities? If Yes, please provide details of the planned activities. * Yes ☐ No ☐
5. Please provide your annual funding or gross revenue: _____
6. Do you expect a material change in your operations in the next 12 months? If Yes, please provide details. * Yes ☐ No ☐
7. Please list any subsidiaries or related entities of your organization, including auxiliaries, foundations or profit-making corporations that are controlled by or control your organization:

Entity Name	Description of Operations	Relationship to Named Insured

Section 2: Operations

1. Please indicate the number of beds you are licensed for:

____ Assisted Living	____ Hospice Care	____ Palliative Care
____ Chronic Care	____ Independent Living	____ Respite Care
____ Complex Continuing Care	____ Life Lease	____ Other – please specify below:
____ Dementia Care	____ Nursing Home/Long-Term Care	

2. Please indicate the number of adult day spots that you operate? _____
3. Please indicate the association memberships you currently hold: _____
4. If you are accredited, please provide the date the last accreditation was awarded: _____
5. Do you administer medication? Yes ☐ No ☐
6. Do you participate in any kind of clinical trial? If Yes, please complete the appropriate addendum. Yes ☐ No ☐
7. Do you provide transportation services to your clients? Yes ☐ No ☐
8. Do your employees and/or volunteers drive their own vehicles while conducting your business? Yes ☐ No ☐
9. If yes to 8., do they report this activity to their automobile insurer? Yes ☐ No ☐
10. If yes to 8., are they required to carry a minimum of $1m Automobile Third Party Liability on their policy? Yes ☐ No ☐
11. If yes to 8., do you require them to provide proof of their automobile insurance? Yes ☐ No ☐

Section 3: Staffing

1. Please indicate the number of your salaried staff by Full Time Equivalent (FTE):

____ Acupuncturists	____ Nurse Aides/Care Aides	____ Registered Practical Nurses
____ Audiologists/Speech Language	____ Nurse Practitioners	____ Registered Psychiatric Nurses
____ Chiropodists/Podiatrists	____ Personal Support Workers	____ Respiratory Therapists
____ Chiropractors	____ Pharmacists	____ Administration, Food Services,
____ Dentists	____ Psychiatrists	Housekeeping, Maintenance,
____ Dental Assistants/Hygienists	____ Psychologists	Management, etc.
____ Dieticians/Nutritionists	____ Recreation/Activation Therapists	____ Other - please specify below:
____ Kinesiologists	____ Registered Massage Therapists	_____
____ Licensed Practical Nurses	____ Registered Nurses	

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

SIGNAL UNDERWRITING

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

#	*Professional Description*				

3. Do you assume liability for the individuals noted in 2. above through their employment contract?	Yes	O	No	O
4. Are all staff Physicians, Dentists and Chiropractors (not in an admin role) members of their mutual defense organisation (i.e., CMPA, CCMC, CCPA)?	Yes	O	No	O
5. Do you conduct employment reference checks on all employees and volunteers?	Yes	O	No	O
6. Do you conduct criminal background checks on all employees and volunteers?	Yes	O	No	O
7. Please provide the total number of volunteers:				
8. Do your employees and/or volunteers enter client residences?	Yes	O	No	O
9. Are all your employees covered by Provincial Workers' Compensation Plans?	Yes	O	No	O
10. Do you provide written warnings to employees to create a record of performance issues?	Yes	O	No	O
11. Do you consult a lawyer prior to dismissing any employee?	Yes	O	No	O

Section 4: Abuse Prevention and Protocols

1. Do you work with minors or the developmentally delayed?	Yes	O	No	O
2. Do you have overnight or one-on-one exposure with minors or the developmentally delayed?	Yes	O	No	O
3. Do you have a formal written policy that prohibits abuse and sexual misconduct?	Yes	O	No	O
4. Do you have a formal complaints procedure for clients and employees to report abuse?	Yes	O	No	O
5. Do you conduct abuse prevention and awareness training for at risk persons?	Yes	O	No	O
6. Have clients or employees made any allegations against any person associated with your organization in the past 5 years? If yes, please provide additional details.*	Yes	O	No	O

Section 5: Residential Care

1. Please indicate the owners' years of experience in a similar health field:				
2. Please indicate the management's years of experience in a similar health field:				
3. What type of Medication Administrative System do you use (e.g., unit dose, blister pack)?				
4. Do all patients have their own attending physician?	Yes	O	No	O
5. Do you employ or contract with a registered Pharmacist to supervise pharmacy services?	Yes	O	No	O
6. Do you review residents' drug regimes on a regular basis?	Yes	O	No	O
7. Do you have a system in place to track medication errors?	Yes	O	No	O
8. Do you assess each resident when they are admitted – including risk for falls, hazardous elopement, skin breakdown, suicide, and violence?	Yes	O	No	O
9. Do you review and revisit residents' assessments on a regular basis?	Yes	O	No	O
10. Do you have a Fall Prevention Program in place?	Yes	O	No	O
11. If Yes to 10., does it include implementing fall precautions based on assessments and a tool for these assessments, and are falls tracked to identify patterns or problems?	Yes	O	No	O
12. Do you use Wander Guard of similar devices for elopement prevention?	Yes	O	No	O
13. Are your stairwells, exits and entrances always alarmed, and/or have individual-specific electronic sensors been installed?	Yes	O	No	O
14. Do you have an Infection Control Program in place?	Yes	O	No	O
15. Do you conduct skin assessments on a regular basis?	Yes	O	No	O
16. Do you offer immunization against seasonal flu to residents and staff annually?	Yes	O	No	O
17. Do you have an Outbreak Management Plan?	Yes	O	No	O
18. Do your facilities have hand hygiene protocols?	Yes	O	No	O
19. Do you train and educate staff and volunteers on hand hygiene?	Yes	O	No	O
20. Do you have an evacuation and fire life safety plans in place and is training conducted?	Yes	O	No	O
21. Please indicate the number of fire drills conducted per year:				

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

22. Do you conduct the fire drills with the minimum of staff that will be on duty day or night? Yes O No O
23. Do you hire independent contractors to maintain the location? If Yes, please provide details.* Yes O No O
24. Do you obtain a Certificate of Insurance for each independent contractor? Yes O No O

Section 6: Claims History

1. Have you ever had a claim against your organisation's insurance policies? If Yes, please provide details including date of loss, amount paid or held in reserve, and description of allegation.* Yes O No O
2. Are you aware of any incidents or circumstances that could potentially give rise to a claim? If Yes, please provide details.* Yes O No O

Section 7: Prior Insurance

1. Have you ever been declined coverage, cancelled or non-renewed for insurance requested in this application? Yes O No O

2. Please provide details of your expiring insurance policy:

Coverage	Insurer	Limit	Aggregate	Deductible	Retroactive Date	Premium
General Liability						
Medical Malpractice						
Abuse						
Non-Profit D&O						

Section 8: Requested Insurance Coverage

1. Please indicate the coverage limit, aggregate, retroactive date, and deductible are requested:

Coverage	Limit	Aggregate	Deductible	Retroactive Date
General Liability				
Medical Malpractice				
Abuse				
Non-Profit D&O				

2. Confirm coverage has been in place continuously from Retroactive Dates requested? Yes O No O

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

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

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:

Senior Care Application Addenda

Please complete the relevant section(s) to your operations.

If you are an existing Insured with SIGNAL Underwriting, has already completed the relevant addendum section(s) and there has been no material changes since completion, the addendum section(s) are not required to be completed.

Addendum: Risk Management

1. Does your governing board have a formal process for oversight of risk management that includes receipt of regular reports outlining the activities of risk management?	Yes O	No O
2. Are the roles and responsibilities of the Risk Manager, committee, or group coordinating risk management clearly stated for its functions such as infection control, health and safety, morbidity, and morality?	Yes O	No O
3. Are your managers' roles in risk management clearly defined?	Yes O	No O
4. Are the procedures for incident reporting documented, disseminated, and implemented throughout your organisation?	Yes O	No O
5. Do you have procedures for the compilation, completion, use, storage and retrieval of patients' or residents' paper or electric records and are they regularly monitored?	Yes O	No O
6. Are all procedures preceded by obtaining informed consent?	Yes O	No O
7. Do you have formal procedures in place to manage complaints?	Yes O	No O
8. Do you review your policies, procedures, protocols, and guidelines at least every three years and are there systems in place to disseminate them to staff?	Yes O	No O
9. Do you have a communication policy that identifies the key channels of communication within and external to the organisation?	Yes O	No O
10. Do you have formal procedures for the selection, recruitment, orientation, and performance management of staff?	Yes O	No O
11. Do you have formal medical staff credentialling program that includes initial credentialling, privilege delineation, and recredentialling?	Yes O	No O
12. Do you have written policies related to health and safety, fire life safety and security?	Yes O	No O

Addendum: Infection Control

1. Do you have an Infection Control Program?	Yes O	No O
2. Is immunization against flu offered to residents and staff annually?	Yes O	No O
3. Is there an Outbreak Management Plan?	Yes O	No O
4. Does the facility have hand hygiene protocols?	Yes O	No O
5. Is education and training provided to staff and volunteers on hand hygiene?	Yes O	No O

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

Addendum: Clinical Trials

1. Please indicate the area of research in which the clinical trials are being conducted: _____
2. Please indicate what current Phase of clinical trial: _____
3. Please indicate the number of participants: _____
4. Does the clinical trial involve any of the following: minors, infants, women that are known to be pregnant or on birth control, genetic engineering, gene therapy, an invasive practice, or ethical implications? Yes O No O
5. Do you assume liability under contract for the trial product? Yes O No O
6. Does the contract have hold harmless agreements in place in favour of your organization? Yes O No O
7. Did a member of staff or physician practicing at your facility write the clinical trial protocols? Yes O No O
8. Is the presiding physician a member of the CMPA? Yes O No O
9. Does the clinical trial include clear informed consent for all potential participants? Yes O No O

Addendum: Non-Profit Directors & Officers Liability

1. How many directors and officers sit on your board of directors? _____
2. Are you in arears in your payment of funds payable to Canada Revenue Agency or any the provincial ministries of revenue (including source deductions, GST, PST, or HST)? Yes O No O
3. Have you defaulted on any loans or fallen in breach of any debt covenants in the past 5 years or anticipate such breach occurring in the next 12 months? Yes O No O
4. Do you have plans to wind up your organisation in the next 12 months? Yes O No O
5. Do you have a fiduciary responsibility for your employee pension plan? Yes O No O
6. In the past 24 months have there been any or are you planning any layoffs in the next 12 months? Yes O No O
7. Have there been any changes in the past 12 months or do you anticipate changes in:
    a. Your subsidiaries, whether being added or removed? Yes O No O
    b. The number of directors and officers? Yes O No O
    c. Your basis of funding? Yes O No O

Please include with your application your latest financial statements and list of duly elected directors and officers.

Without limitation or any other remedy available to the insurers, the applied for insurance will not afford coverage to any claims which any insured has knowledge nor any claims resulting from any facts or circumstances of which any insured has knowledge.

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