

Foster and Child Care Services 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 what percentage (%) of your operations would include the following (total of all sections should equal 100%):

%	Description of Operations	%	Description of Operations	%	Description of Operations
	Foster & Childcare Services				

2. Please indicate the number of group homes and/or staffed foster care facilities you operate: _____
3. Please indicate the percentage of your group homes and/or staffed foster care facilities are co-ed: _____
4. Please indicate the number classroom locations you operate: _____
5. Please indicate the number of children and youth in your classrooms: _____
6. Please indicate the number of Serious Occurrence Reports that were reported in the last 12 months? _____
7. Is your organization currently licensed with the appropriate provincial ministry or agency? Yes No
8. Have all issues and/or recommendations from previous Serious Occurrence Reports been addressed? Yes No
9. Do you have a formal process to assess children and youth in your care for potential mental health issues? Yes No
10. Do you have children or youth that have a history with Justice Canada in your care? Yes No
11. If Yes to 10., have any individuals previously had issues with fire setting? Yes No
12. If Yes to 10. and 11., do you have formal process to assess and monitor these individuals behaviours? Yes No
13. Does your organization have the authority to remove children from their families? Yes No
14. Does your organization have the final approval of any potential foster parent applicants? Yes No
15. Does your organization conduct random inspections on the homes of foster parents? Yes No
16. Please indicate the owner's years of experience in a similar health field: _____
17. Please indicate the management's years of experience in a similar health field: _____
18. Does your organization provide day camps? If yes, please provide details.* Yes No
19. Do you provide transportation services to your clients? Yes No
20. Do your employees and/or volunteers drive their own vehicles on your business? Yes No
21. If yes to 20., do they report this activity to their automobile insurer? Yes No
22. If yes to 20., are they required to carry a minimum of \$1m Automobile Third Party Liability on their policy? Yes No
23. If yes to 20., do you require them to provide proof of their automobile insurance? Yes No

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

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Section 3: Staffing

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

	Case Managers		Nursing Assistants/Nurse Aides		Social Workers
	Case Workers		Personal Support Workers		Administration, Food Services,
	Counsellors/Mental Health Workers		Psychologists		Housekeeping, Maintenance,
	Dieticians/Nutritionists		Registered Nurses		Management, etc.
	Licensed Practical Nurses		Registered Practical Nurses		Other, please specify below:
	Nurse Practitioners		Registered Psychiatric Nurses		

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 No
4. Do you conduct employment reference checks on all employees and volunteers? Yes No
5. Do you conduct criminal background checks on all employees and volunteers? Yes No
6. Please indicate your annual payroll: _____
7. Please provide the total number of volunteers: _____
8. Do your employees and/or volunteers enter client residences? Yes No
9. Are all your employees covered by Provincial Workers' Compensation Plans? Yes No
10. Do you provide written warnings to employees to create a record of performance issues? Yes No
11. Do you consult a lawyer prior to dismissing any employee? Yes No
12. Do you have a current copy of the Employment Standards Act accessible for staff? Yes No

Section 4: Group Home Beds and Staffed Foster Beds

Please indicate the number of group home beds and staffed foster beds you are licensed for by the following category:

	Group Home Beds – Adults		Staffed Foster Beds – Adults		Other - please specify below:
	Group Home Beds – Minors		Staffed Foster Beds – Minors		

Section 5: Foster Children Spots and Youth Under Care

Please indicate the total number of foster children spots you are licensed for, the annual average occupancy and youth under care:

	Total Licensed Foster Children Spots		Average Number of Foster Children		Independent Supported Living
	Total Youth Under Agency's Care		Total Youth with Justice Canada History		

Section 6: Abuse Prevention and Protocols

1. Do you have a formal complaints procedure for clients and employees to report abuse? Yes No
2. Do you have a formal written policy that prohibits abuse and sexual misconduct? Yes No
3. Do you conduct prevention and awareness for training child and/or at-risk persons abuse? Yes No
4. Have clients or employees made any allegations against any person associated with your organization in the past 10 years? If yes, please provide additional details.* Yes No

Section 7: 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 No
2. Are you aware of any incidents or circumstances that could potentially give rise to a claim? If Yes, please provide details.* Yes No

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

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Section 8: Prior Insurance

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

2. Please provide details of your expiring insurance policy:

Coverage	Insurer	Limit	Aggregate	Deductible	Retroactive Date	Premium
General Liability						
Medical Malpractice						
Abuse						

Section 9: 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				

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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Foster Care Agencies and Group Homes Application Addenda

Please complete the section(s) relevant 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: Non-Profit Directors & Officers Liability

- | | | | |
|--|-----|-----------------------|--------------------------|
| 1. How many directors and officers sit on your board of directors? | | | |
| 2. Are you in arrears 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 | <input type="radio"/> | No <input type="radio"/> |
| 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 | <input type="radio"/> | No <input type="radio"/> |
| 4. Do you have plans to wind up your organisation in the next 12 months? | Yes | <input type="radio"/> | No <input type="radio"/> |
| 5. Do you have a fiduciary responsibility for your employee pension plan? | Yes | <input type="radio"/> | No <input type="radio"/> |
| 6. In the past 24 months have there been any or are you planning any layoffs in the next 12 months? | Yes | <input type="radio"/> | No <input type="radio"/> |
| 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 | <input type="radio"/> | No <input type="radio"/> |
| b. The number of directors and officers? | Yes | <input type="radio"/> | No <input type="radio"/> |
| c. Your basis of funding? | Yes | <input type="radio"/> | No <input type="radio"/> |

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.