Healthcare 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. 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%):**

	Alcohol & Drug Programs/Treatment		**Emergency Care/Patient Transfer**		**Mental Health Programs/Treatment**
	Counselling		Air Ambulance Services		Adult Day Programs
	Detoxification		Ambulance Services		Counselling
	Methadone/Suboxone Clinic		Non-Emergency Patient Transport		Crisis Intervention
	Residential Treatment		Paramedic Services, First Aid		Homeless Initiatives
	Peer Support		**Medical Clinics**		Peer Support, Community Support
	Transitional Housing		Birthing Clinic, Perinatal Facilities		Residential Care
	Community Support Programs		Cancer IV Therapy		Residential Care: Developmental
	Adult Day Programs		Dental Clinic and Offices		Shelters
	Education, Promotion, Information		Dialysis		Transitional Housing
	Foster & Childcare Services		Family & Walk-in Clinics		Women's & Family Shelters
	Meal Support Services		Family Health Team		**Palliative Care / Home Care**
	Nursing Placement Agency		Fertility Clinic, IVF		Hospice and Palliative Care
	Public Health		General Practice		Nursing Care at Home
	Tele-Health		Naturopathy, Homeopathy, Holistic		Personal Support Care at Home
	Diagnostic Imaging and Testing		Transfusions		Respite
	Computed Tomography (CT)		Women's Health		**Surgical**
	Diagnostic Laboratory		**Medical Rehabilitation**		Bariatric Surgery: Laparoscopic
	Magnetic Resonance Imaging (MRI)		Chiropractic		Cosmetic Surgery
	Nuclear Medicine, PET		Chronic Care		Dental Surgery
	Phlebotomy, Sample Collection		Complex Continuing Care		Diagnostic Procedures, Endoscopy
	Radiography, X-ray, Fluoroscopy		Medical Assessments		Hair Transplants
	Ultrasound, Sonography		Occupational Therapy		Laser Eye Surgery
			Physiotherapy, Kinesiology		Ophthalmic Surgical Centre
			Sports Therapy: Amateurs		Private Surgical Centre

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

Other: Please describe below and provide percentage (%)					
%	*Description of Operations*				

2. Please indicate the association memberships you currently hold:

3. If you are accredited, please provide the date of when the last accreditation was awarded:

4. Do you administer medication? Yes O No O

5. Do you provide intubation services? Yes O No O

6. Do you provide pre-natal diagnosis and/or screening? Yes O No O

7. If yes to 6., are you interpreting results/providing diagnosis of the scans or tests? Yes O No O

8. Please provide the annual number of client, clinic, or lab visits:

9. What percentage of clients/patients treated are non-Canadian residents:

10. Do you participate in any kind of clinical trial? If Yes, please complete the addendum. Yes O No O

11. Do you provide transportation services to your clients? Yes O No O

12. Do your employees and/or volunteers drive their own vehicles on your business? Yes O No O

13. If yes to 12., do they report this activity to their automobile insurer? Yes O No O

14. If yes to 12., are they required to carry a minimum of $1m Automobile Third Party Liability on their policy? Yes O No O

15. If yes to 12., do you require them to provide proof of their automobile insurance? Yes O No O

Section 3: Staffing

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

	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				

4. Do you assume liability for the individuals noted in 2. above through their employment contract? Yes O No O

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

5. Are all staff Physicians, Dentists and Chiropractors (not in an admin role) members of their mutual defense organisation (i.e., CMPA, CDSPI, CCPA)?	Yes O	No O
6. Do you conduct employment reference checks on all employees and volunteers?	Yes O	No O
7. Do you conduct criminal background checks on all employees and volunteers?	Yes O	No O
8. Please provide the total number of volunteers:		
9. Do your employees and/or volunteers enter client residences?	Yes O	No O
10. Are all your employees covered by Provincial Workers' Compensation Plans?	Yes O	No O
11. Do you provide written warnings to employees to create a record of performance issues?	Yes O	No O
12. Do you consult a lawyer prior to dismissing any employee?	Yes O	No O
13. Do you have a current copy of the Employment Standards Act accessible for staff?	Yes O	No O

Section 4: 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		

Section 5: 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 prevention and awareness for training child and/or at-risk persons abuse?	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 6: Products

1. Do you sell any products as part of your operations?	Yes O	No O
2. Please indicate how much revenue comes from the sale of these products:		
3. Are any of these products sold outside of Canada?	Yes O	No O
4. Are any of these products sold under your organization's name or brand(s)?	Yes O	No O
5. Please indicate what type of products you sell?*		

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 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 8: 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						

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

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

Additonal 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.

SIGNAL UNDERWRITING

Healthcare 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: Risk Management (for all organisations)

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: Addiction Programs

1. If a residential program, do the residents have private accommodations?	Yes O	No O
2. If a residential program, are regular and random wellness checks conducted during the night?	Yes O	No O
3. If a residential program, are residents escorted when leaving the premises during the first 2 weeks?	Yes O	No O
4. Is medical detox conducted by an experienced medical professional?	Yes O	No O

Addendum: Childminding

1. Do you provide childminding as part of your services to your patients?	Yes O	No O
2. What is the range of age of the children?		
3. Do you obtain written instructions from parents on allergic or medical problems?	Yes O	No O
4. Are all childminding staff trained in first aid?	Yes O	No O

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

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

Addendum: Crisis, Women's and Family, Homeless Shelters

1. Does the shelter operate a safe home system?	Yes O	No O
2. Are emergency exits clearly marked and clear of obstructions?	Yes O	No O
3. Are shelter staff trained to deal with aggressive persons?	Yes O	No O
4. Do you take responsibility for securing a resident's personal property?	Yes O	No O
5. Do you have a protocol and procedures for evicting a resident?	Yes O	No O
6. Are first aid kits placed throughout the shelter?	Yes O	No O
7. Do members of the staff ever make decisions regarding the care of a person's child? If so, provide details.*	Yes O	No O
8. Are staff members trained to recognize a battered person's need for emergency medical assistance?	Yes O	No O
9. If a woman's/family shelter, do you keep the location secret and maintain client confidentiality?	Yes O	No O
10. If a woman's/family shelter, do any male staff or volunteers have direct contact with residents?	Yes O	No O

Addendum: Diagnostic Testing and Imaging

1. Is screening performed prior to diagnostic testing (e.g., subcutaneous metals before MRI) where applicable?	Yes O	No O
2. Do you have clear procedures and protocols for the timely communication of results?	Yes O	No O
3. Do you require patients that have received anaesthesia to be collected and escorted home?	Yes O	No O
4. Are you involved with genetic testing?	Yes O	No O
5. Do you provide non-medically necessary ('vanity scans') sonographs?	Yes O	No O

Addendum: Emergency and Non-Emergency Patient Transportation

1. Please indicate the number of ambulances you operate:	_____	
2. Please indicate the average number of trips taken per year:	_____	
3. Please indicate the types of paramedics employed:	_____	
4. Do you provide services outside of Canada?	Yes O	No O
5. Do you own and/or operate an aircraft as part of your operations?	Yes O	No O

Addendum: Medical Assessments

1. Are the assessments taking place in person?	Yes O	No O
2. Are medical assessments conducted by anyone other than a medical doctor or registered nurse? If Yes, please provide details.*	Yes O	No O
3. Are all assessments conducted on Canadian residents?	Yes O	No O
4. Please indicate what type of assessments are taking place (e.g., worksite, functional abilities evaluations, in-home assessments):	_____	
5. You confirm that they understand any quote for coverage will not include financial loss other than provided for Medical Malpractice.	Confirmed O	

Addendum: Medical Equipment

1. Is the current guidance for infection prevention and control, including the sterilization of medical instruments and devices, followed?	Yes O	No O
2. Do you have a preventative maintenance program for all necessary equipment?	Yes O	No O
3. Do you keep records of inspections, maintenance, calibration, and testing of equipment?	Yes O	No O
4. Do you adhere to the manufacturers' recommendation for the inspection and maintenance of equipment?	Yes O	No O

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

Addendum: Mental Health

1. Do you provide past-life regression therapy?	Yes O	No O
2. Do you provide a crisis hotline? If Yes, please provide details of services provided to callers.*	Yes O	No O
3. Do volunteers ever work the hotline without supervision?	Yes O	No O
4. Do you provide specific training to hotline workers and volunteers?	Yes O	No O
5. Do you provide instructions in crisis counselling for situations involving suicide, rape or domestic violence?	Yes O	No O

Addendum: Nursing Placement Agency, Medical Personnel Agency

1. Please indicate at what type of medical institutions staff are being placed:	Yes O	No O
2. Do you assume liability for the staff placed through the contract with the facility?	Yes O	No O
3. Do you assume liability for the staff through their employment contracts with the individuals?	Yes O	No O
4. Are the placed staff required to carry their own insurance?	Yes O	No O

Addendum: Residential Care and Treatment

1. Please indicate the years of experience in a similar health field for the owners/management:		
2. What type of Medication Administrative System do you use (e.g., unit dose, blister pack)?		
3. Do you employ or contract with a registered Pharmacist to supervise pharmacy services?	Yes O	No O
4. Do you review residents' drug regimes on a regular basis?	Yes O	No O
5. Do you have a system in place to track medication errors?	Yes O	No O
6. Do you have an Infection Control Program in place?	Yes O	No O
7. Do you offer immunization against seasonal flu to residents and staff annually?	Yes O	No O
8. Do you have an Outbreak Management Plan?	Yes O	No O
9. Do your facilities have hand hygiene protocols?	Yes O	No O
10. Do you provide education and training to staff and volunteers on hand hygiene?	Yes O	No O
11. Do you have an evacuation and fire life safety plans in place and is training conducted?	Yes O	No O
12. Please indicate the number of fire drills conducted per year:		
13. Do you conduct the fire drills with the minimum of staff that will be on duty day or night?	Yes O	No O
14. Do you hire independent contractors to maintain the location? If Yes, please provide details.*	Yes O	No O
15. Do you obtain a Certificate of Insurance for each independent contractor?	Yes O	No O

Addendum: Surgical

1. Please provide the number and types of procedures provided on average per year in the Additional Information section.		
2. Have you implemented a Surgical Safety Checklist?	Yes O	No O
3. Do you require patients that have received anaesthesia to be collected and escorted home?	Yes O	No O
4. Are all surgery patients screened to exclude high risk patients by ASA risk score or similar?	Yes O	No O
5. If cosmetic surgery, please indicate the practicing surgeons' years of experience in the procedures being provided:		

Addendum: Water Testing and Monitoring

1. Are you responsible for the testing of and monitoring of the local water supply?	Yes O	No O
2. Are all water samples collected sent to Health Canada for testing?	Yes O	No O
3. Do you conduct testing with mass produced testing kit?	Yes O	No O
4. Do you conduct the testing with an onsite lab?	Yes O	No O

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