

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, Housekeeping, Maintenance, Management, etc.
_____ Dentists	_____ Psychiatrists	_____ Other - please specify below:
_____ Dental Assistants/Hygienists	_____ Psychologists	_____
_____ Dieticians/Nutritionists	_____ Recreation/Activation Therapists	_____
_____ Kinesiologists	_____ Registered Massage Therapists	_____
_____ Licensed Practical Nurses	_____ Registered Nurses	_____

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

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. Are all staff Physicians, Dentists and Chiropractors (not in an admin role) members of their mutual defense organisation (i.e., CMPA, CCMC, CCPA)? Yes No
- 5. Do you conduct employment reference checks on all employees and volunteers? Yes No
- 6. Do you conduct criminal background checks on all employees and volunteers? Yes No
- 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

Section 4: Abuse Prevention and Protocols

- 1. Do you work with minors or the developmentally delayed? Yes No
- 2. Do you have overnight or one-on-one exposure with minors or the developmentally delayed? Yes No
- 3. Do you have a formal written policy that prohibits abuse and sexual misconduct? Yes No
- 4. Do you have a formal complaints procedure for clients and employees to report abuse? Yes No
- 5. Do you conduct abuse prevention and awareness training for at risk persons? Yes No
- 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 No

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 No
- 5. Do you employ or contract with a registered Pharmacist to supervise pharmacy services? Yes No
- 6. Do you review residents' drug regimes on a regular basis? Yes No
- 7. Do you have a system in place to track medication errors? Yes No
- 8. Do you assess each resident when they are admitted – including risk for falls, hazardous elopement, skin breakdown, suicide, and violence? Yes No
- 9. Do you review and revisit residents' assessments on a regular basis? Yes No
- 10. Do you have a Fall Prevention Program in place? Yes No
- 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 No
- 12. Do you use Wander Guard of similar devices for elopement prevention? Yes No
- 13. Are your stairwells, exits and entrances always alarmed, and/or have individual-specific electronic sensors been installed? Yes No
- 14. Do you have an Infection Control Program in place? Yes No
- 15. Do you conduct skin assessments on a regular basis? Yes No
- 16. Do you offer immunization against seasonal flu to residents and staff annually? Yes No
- 17. Do you have an Outbreak Management Plan? Yes No
- 18. Do your facilities have hand hygiene protocols? Yes No
- 19. Do you train and educate staff and volunteers on hand hygiene? Yes No
- 20. Do you have an evacuation and fire life safety plans in place and is training conducted? Yes No
- 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 No
23. Do you hire independent contractors to maintain the location? If Yes, please provide details.* Yes No
24. Do you obtain a Certificate of Insurance for each independent contractor? Yes No

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 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

Section 7: 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						
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 No

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 No
- 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 mortality? Yes No
- 3. Are your managers’ roles in risk management clearly defined? Yes No
- 4. Are the procedures for incident reporting documented, disseminated, and implemented throughout your organisation? Yes No
- 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 No
- 6. Are all procedures preceded by obtaining informed consent? Yes No
- 7. Do you have formal procedures in place to manage complaints? Yes No
- 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 No
- 9. Do you have a communication policy that identifies the key channels of communication within and external to the organisation? Yes No
- 10. Do you have formal procedures for the selection, recruitment, orientation, and performance management of staff? Yes No
- 11. Do you have formal medical staff credentialing program that includes initial credentialing, privilege delineation, and recredentialing? Yes No
- 12. Do you have written policies related to health and safety, fire life safety and security? Yes No

Addendum: Infection Control

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

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

Addendum: Clinical Trials

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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 No
 5. Do you assume liability under contract for the trial product? Yes No
 6. Does the contract have hold harmless agreements in place in favour of your organization? Yes No
 7. Did a member of staff or physician practicing at your facility write the clinical trial protocols? Yes No
 8. Is the presiding physician a member of the CMPA? Yes No
 9. Does the clinical trial include clear informed consent for all potential participants? Yes No

Addendum: Non-Profit Directors & Officers Liability

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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 No
 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 No
 4. Do you have plans to wind up your organisation in the next 12 months? Yes No
 5. Do you have a fiduciary responsibility for your employee pension plan? Yes No
 6. In the past 24 months have there been any or are you planning any layoffs in the next 12 months? Yes No
 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 No
 - b. The number of directors and officers? Yes No
 - c. Your basis of funding? Yes No

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.