

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 describe operations:

3. Please indicate the association memberships you currently hold:

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

5. Do you administer medication?

Yes No

6. Do you provide intubation services?

Yes No

7. Do you provide pre-natal diagnosis and/or screening?

Yes No

8. If yes to 6., are you interpreting results/providing diagnosis of the scans or tests?

Yes No

9. If yes to 6., do you confirm the laboratory has insurance?

Yes No

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

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

Yes No

12. Do you participate in any kind of clinical trial? If Yes, please complete the addendum.

Yes No

13. Do you provide transportation services to your clients?

Yes No

14. Do your employees and/or volunteers drive their own vehicles on your business?

Yes No

15. If yes to 12., do they report this activity to their automobile insurer?

Yes No

16. If yes to 12., are they required to carry a minimum of \$1m Automobile Third Party Liability on their policy?

Yes No

17. If yes to 12., 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 (**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
Chiropractors/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	

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

Section 4: Beds

Please indicate the number of beds you are licensed for:

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

Section 5: 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 children and/or 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 6: Products

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

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						
Non-Profit D&O						

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				
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 _____

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.

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

Addendum: Addiction Programs

- | | | | | |
|---|-----|-----------------------|----|-----------------------|
| 1. If a residential program, do the residents have private accommodations? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 2. If a residential program, are regular and random wellness checks conducted during the night? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 3. If a residential program, are residents escorted when leaving the premises during the first 2 weeks? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 4. Is medical detox conducted by an experienced medical professional? | Yes | <input type="radio"/> | No | <input type="radio"/> |

Addendum: Childminding

- | | | | | |
|---|-----|-----------------------|----|-----------------------|
| 1. Do you provide childminding as part of your services to your patients? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 2. What is the range of age of the children? | | | | |
| 3. Do you obtain written instructions from parents on allergic or medical problems? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 4. Are all childminding staff trained in first aid? | Yes | <input type="radio"/> | No | <input type="radio"/> |

Addendum: Clinical Trials

- | | | | | |
|---|-------|-----------------------|----|-----------------------|
| 1. Please indicate the area of research in which the clinical trials are being conducted: | <hr/> | | | |
| 2. Please indicate what current Phase of clinical trial: | <hr/> | | | |
| 3. Please indicate the number of participants: | <hr/> | | | |
| 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 | <input type="radio"/> | No | <input type="radio"/> |
| 5. Do you assume liability under contract for the trial product? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 6. Does the contract have hold harmless agreements in place in favour of your organization? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 7. Did a member of staff or physician practicing at your facility write the clinical trial protocols? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 8. Is the presiding physician a member of the CMPA? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 9. Does the clinical trial include clear informed consent for all potential participants? | Yes | <input type="radio"/> | No | <input type="radio"/> |

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

Addendum: Diagnostic Testing and Imaging

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

Scan Type	Number of Scans	Scan Type	Number of Scans

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 No
- 5. Do you own and/or operate an aircraft as part of your operations? Yes No

Addendum: Medical Assessments

- 1. Are the assessments taking place in person? Yes No
- 2. Are medical assessments conducted by anyone other than a medical doctor or registered nurse? If Yes, please provide details.* Yes No
- 3. Are all assessments conducted on Canadian residents? Yes No
- 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

Addendum: Medical Equipment

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

*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 | <input type="radio"/> | No | <input type="radio"/> |
| 2. Do you provide a crisis hotline? If Yes, please provide details of services provided to callers.* | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 3. Do volunteers ever work the hotline without supervision? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 4. Do you provide specific training to hotline workers and volunteers? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 5. Do you provide instructions in crisis counselling for situations involving suicide, sexual assault, or domestic violence?, | Yes | <input type="radio"/> | No | <input type="radio"/> |

Addendum: Nursing Placement Agency, Medical Personnel Agency

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

Addendum: Residential Care and Treatment, Group Homes

- | | | | | |
|--|-----|-----------------------|----|-----------------------|
| 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 | <input type="radio"/> | No | <input type="radio"/> |
| 4. Do you review residents’ drug regimes on a regular basis? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 5. Do you have a system in place to track medication errors? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 6. Do you have an Infection Control Program in place? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 7. Do you offer immunization against seasonal flu to residents and staff annually? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 8. Do you have an Outbreak Management Plan? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 9. Do your facilities have hand hygiene protocols? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 10. Do you provide education and training to staff and volunteers on hand hygiene? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 11. Do you have an evacuation and fire life safety plans in place and is training conducted? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 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 | <input type="radio"/> | No | <input type="radio"/> |
| 14. Do you hire independent contractors to maintain the location? If Yes, please provide details.* | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 15. Do you obtain a Certificate of Insurance for each independent contractor? | Yes | <input type="radio"/> | No | <input type="radio"/> |

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 | <input type="radio"/> | No | <input type="radio"/> |
| 3. Do you require patients that have received anaesthesia to be collected and escorted home? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 4. Are all surgery patients screened to exclude high risk patients by ASA risk score or similar? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 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 | <input type="radio"/> | No | <input type="radio"/> |
| 2. Are all water samples collected sent to Health Canada for testing? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 3. Do you conduct testing with mass produced testing kit? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 4. Do you conduct the testing with an onsite lab? | Yes | <input type="radio"/> | No | <input type="radio"/> |

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

Addendum: Youth and Foster Care

- | | |
|---|--|
| 1. Please indicate the percentage of your group homes and/or staffed foster care facilities are co-ed: | _____ |
| 2. Please indicate the number classroom locations you operate: | _____ |
| 3. Please indicate the number of children and youth in your classrooms: | _____ |
| 4. Please indicate the number of Serious Occurrence Reports that were reported in the last 12 months? | _____ |
| 5. Is your organization currently licensed with the appropriate provincial ministry or agency? | Yes <input type="radio"/> No <input type="radio"/> |
| 6. Have all issues and/or recommendations from previous Serious Occurrence Reports been addressed? | Yes <input type="radio"/> No <input type="radio"/> |
| 7. Do you have a formal process to assess children and youth in your care for potential mental health issues? | Yes <input type="radio"/> No <input type="radio"/> |
| 8. Do you have children or youth that have a history with Justice Canada in your care? | Yes <input type="radio"/> No <input type="radio"/> |
| 9. If Yes to 8., have any individuals previously had issues with fire setting? | Yes <input type="radio"/> No <input type="radio"/> |
| 10. If Yes to 8. and 9., do you have formal process to assess and monitor these individuals behaviours? | Yes <input type="radio"/> No <input type="radio"/> |
| 11. Does your organization have the authority to remove children from their families? | Yes <input type="radio"/> No <input type="radio"/> |
| 12. Does your organization have the final approval of any potential foster parent applicants? | Yes <input type="radio"/> No <input type="radio"/> |
| 13. Does your organization conduct random inspections on the homes of foster parents? | Yes <input type="radio"/> No <input type="radio"/> |
| 14. Does your organization provide day camps? If yes, please provide details.* | Yes <input type="radio"/> No <input type="radio"/> |

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.

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