

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. Have your operations changed from what was reported previously? If Yes, please provide details.* | Yes ☐ | No ☐ |
| 2. Do you expect a material change in your operations in the next 12 months? If Yes, please provide details.* | Yes ☐ | No ☐ |
| 3. Have any of your best practices or risk management protocols changed? If Yes, please provide details.* | Yes ☐ | No ☐ |
| 4. Did your organization receive accreditation last year? | Yes ☐ | No ☐ |

Section 2: Beds

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	

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	

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

#	Professional Description				

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.

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

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.