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Application

Errors and Omissions Insurance and Commercial General Liability Insurance for Health Institutions (Nursing and Convalescent Facilities)

Submitting Broker, please complete the following to assist us in processing this submission:

Name of Brokerage: ______________________

Name of Broker Contact: ______________________

Brokerage Address: ______________________ City: ____________ Postal Code: __________

For renewal purposes only: Policy Number: ______________ ISN (Client's Number): ______________

THE APPLICANT

1. Name of Health Institution (Applicant): ______________________

   ____

   If more than one legal entity, please indicate the relationship between each: ______________________

   ____

   (Please note that an insurance policy cannot be shared unless there is a financial interest.)

2. Website Address (if applicable): ______________________

3. Address: ______________________

   ____

4. Location of Branch Offices: ______________________

5. Year operations began: ______________________

6. Type of health institution: ______________________

7. Please indicate the Applicant's gross annual revenue or operating budget:

   Previous Year: $______________ Anticipated: $______________

8. Are all of the facilities licensed facilities? YES ☐ NO ☐

9. What authoritative or regulatory body oversees the operation of the institution?

   ____

10. (a) Date of last accreditation: ______________________

    (b) Accreditation period: ______________________

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11. Has the Applicant ever had its licence revoked, suspended or been placed on probation by any governmental licensing agency? YES ☐ NO ☐

    If yes, please provide details: ______________________________

12. Has the Applicant ever been investigated by a third party for alleged fraud or erroneous billing? YES ☐ NO ☐

    If yes, please provide details: ______________________________

13. Total number of beds: ______________________________

Unit	Number of beds
Developmentally delayed or handicapped	______________
Chronic/Long-term	______________
Medical	______________
Autonomous	______________
Other (specify)	______________

14. Average length of stay: ______________________________

15. Please describe any special care units and state number of beds:

    ____

16. Total number of patients last year: ______________________________

17. Percentage of residents by age range: _____ < 30 _____ 30-64 _____ 65-74

    _____ 75-84 _____ 85-94 _____ > 95

18. Total daily number of outpatients: ______________________________

19. (a) Please indicate the total number of employees:

Profession	Number
Nurses	______________
Nursing Assistants	______________
Social Workers	______________
Other (specify)	______________

    (b) If there are volunteers, please provide on a separate sheet the number, their duties and a description of the training they have received.

N.B. PLEASE NOTE THAT THIS PROPOSED PROFESSIONAL LIABILITY INSURANCE FOR HEALTH INSTITUTIONS EXCLUDES THE SERVICES OF PHYSICIANS, SURGEONS AND DENTISTS WHEN THEY CARRY OUT OR NEGLECT TO CARRY OUT AN ACT IN THE PRACTICE OF THEIR PROFESSION.

20. What are the criteria used for hiring medical staff?

    ____

    ____

21. What is the practice for training new employees?

    ____

    ____

22. Is staff available around the clock every day? YES ☐ NO ☐

23. Does the Applicant provide services or perform activities outside Canada or for clients who are outside Canada? YES ☐ NO ☐

    If yes, please provide full details for our review and acceptance, and indicate the services provided as well as the location and the gross annual fees or income from the past year and anticipated for the next year.

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24. Please list all properties owned, controlled or occupied by the Applicant that are subject to this insurance request:

Address	Rent or Own	Area (m^2)	Age	Construction (frame, brick, etc.)	No. of Stories

25. Was the building converted into a retirement home? YES ☐ NO ☐

    If yes, what was the original purpose of the building? __________

26. Year renovated? __________

27. If the building is over 25 years old, please state if the following items have been renovated and when:

Item	Yes or No	Year
Electric Wiring		
Plumbing		
Heating		
Roof		
Other (specify)		

28. Is the electrical system protected by fuses ☐ or breakers ☐?

29. What is the amperage of the electrical supply? __________

30. Does your facility have an auxiliary power source in the event of a power failure? YES ☐ NO ☐

31. Type of heating? __________

32. Number of elevators? __________

    (a) Are they regularly inspected? YES ☐ NO ☐

    (b) By whom? __________

    (c) Any recommendations made at last inspection? __________

    (d) Were they done? __________

    (e) Is there one elevator or more large enough to carry a bed? YES ☐ NO ☐

33. How many stairwells per floor? __________

34. Any cooking units:

    (a) on floor? YES ☐ NO ☐

    (b) in rooms? YES ☐ NO ☐

    (c) to do frying? YES ☐ NO ☐

    If yes, are they equipped with any extinguishing system of the CO_2 type? YES ☐ NO ☐

    (d) Are they regularly inspected? YES ☐ NO ☐

    (e) By whom? __________

35. Indicate if there is a:

    (a) Pool? YES ☐ NO ☐

    (i) Is the pool locked when not in use? YES ☐ NO ☐

    (ii) Is there a lifeguard on duty? YES ☐ NO ☐

    (iii) Do you have a daily maintenance procedure in place? YES ☐ NO ☐

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(b) Sauna bath? YES ☐ NO ☐

(c) Whirlpool? YES ☐ NO ☐

36. Please describe the fire protection system:

	Yes or No	Number
Fire extinguishers?	____	____
Sprinklers?	____	____
Smoke detectors?	____	____
Fire alarm system?	____	
Fire alarm connected to a central system?	____	
Distance from nearest fire hydrant (in km)?		____
Distance from nearest fire station (in km)?		____
Does the municipality have a full-time fire brigade?	____	
Does the municipality have a volunteer brigade?	____	
How many persons are on duty at night?		____
How many fire exits per floor?		____

37. Who checks fire extinguishers, smoke detectors, sprinklers and alarm systems? ____

38. Please describe or provide any emergency evacuation plan:

(a) in daytime: ____

(b) at night: ____

39. Please describe the spread of patients in the building, taking into consideration the fire exits on the ground floor:

____

____

40. Are invalids located on the lower floor? YES ☐ NO ☐

41. Is the building isolated at least 40 feet from any other structure? YES ☐ NO ☐

42. Are any construction/renovations planned for the next twelve (12) months? YES ☐ NO ☐

If yes, please provide details:

____

43. Any social activities? YES ☐ NO ☐

If yes, please provide details: ____

44. Any sporting activities? YES ☐ NO ☐

If yes, please provide details: ____

45. Is liquor served on the premises? YES ☐ NO ☐

If yes, please provide details: ____

46. Does the Applicant own or operate other business enterprises, related or not to the main activities? YES ☐ NO ☐

If yes, please provide details and indicate if the coverage applied for should include them:

____

47. During the past three (3) years, has the building been inspected:

(a) by the provincial ministry? YES ☐ NO ☐

(b) by an insurance company? YES ☐ NO ☐

If yes, please identify: ____

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(c) by any other organizations? YES ☐ NO ☐

If yes, please identify: ______________________________

Please provide a copy of the most recent inspection report as well as photographs of the facility if these are available.

48. Were any loss control recommendations made pursuant to these inspections? YES ☐ NO ☐

If yes, please provide details of the recommendations and the measures that were taken to comply with these.

49. Does the Applicant provide any transportation services for their patients? YES ☐ NO ☐

If yes, please provide details:

____

50. Are the parking lots and walkways leading up to your facilities in good repair? YES ☐ NO ☐

51. Is there a snow removal contract in place? YES ☐ NO ☐

Who is responsible for determining when the lot should be plowed?

____

52. **Extensions**

(a) ☐ Tenants' Legal Liability

If tenants' legal liability is required, please respond to the following questions:

Please indicate the amount to be insured for each leased location listed in response to question 3.

(i) ______________________________

(ii) ______________________________

(iii) ______________________________

(b) ☐ Non-owned Automobile Liability

If non-owned automobile coverage is required, please respond to the following questions:

(i) Please indicate the number of employees who regularly drive their own vehicle on company business:

____

(ii) Please indicate the number of employees who rent a vehicle (short term) for the purpose of conducting company business at any point throughout the year: ______________________________

(iii) Please state the typical value of a rented vehicle: ______________________________

(iv) Please state the typical type of vehicle rented: ______________________________

(c) ☐ Employee Benefits Liability

(d) ☐ Employers' Bodily Injury Liability

QUALITY CONTROL FOR CARE AND SERVICES

53. Is there an established system to identify risk situations? YES ☐ NO ☐

If yes, please provide details:

____

54. How are complaints handled? ______________________________

55. Does the Applicant have formal documentation procedures for complaints and/or incidents? YES ☐ NO ☐

56. How does the Applicant dispose of contaminated materials? ______________________________

57. What security measures are used to control unauthorized entrance/exits from the facility?

____

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58. (a) Is there a facility "no smoking policy" in effect? YES ☐ NO ☐

(b) Are smoking materials (including matches/lighters):

(i) restricted from a resident's room? YES ☐ NO ☐

(ii) supervised and/or stored in designated areas? YES ☐ NO ☐

INSURANCE COVERAGE - **If you are renewing your policy with Victor, do not complete this section.**

59. (a) Has the Applicant ever previously purchased professional liability or errors and omissions insurance? YES ☐ NO ☐

(b) If yes, please provide the following details for the last three years:

Insurer	Policy Period	Expiring Premium	Limit	Deductible
____________	____________	$____________	$____________	$____________
____________	____________	$____________	$____________	$____________
____________	____________	$____________	$____________	$____________

(c) With respect to (b) above, please indicate if such coverage was offered on an occurrence basis or claims-made basis:

____

If claims-made, what was the retroactive date of the policy (dd/mm/yyyy)? ____________________

60. Has insurance coverage ever been declined or cancelled or the renewal thereof been refused? YES ☐ NO ☐

If yes, please provide details:

____

LOSS EXPERIENCE - **If you are renewing your policy with Victor, do not complete this section.**

61. **Errors and Omissions**

(a) In the past, has the Applicant or any of their employees ever been the recipient of any allegations of professional negligence in writing or verbally? YES ☐ NO ☐

(b) Is the Applicant or any of their employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? YES ☐ NO ☐

If yes, please provide details:

____

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURERS, IT IS AGREED THAT, IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

62. **Commercial General Liability**

Please provide details on the liability claims or potential claims that have come to the Applicant's attention during the past three years. For each incident, detail the date of the loss, nature and cause of the claim, amount claimed, costs actually incurred (claim investigation, defence costs and damages) and status of the claim. Please use a separate sheet of paper.

LIMITS REQUESTED

63. Per claim: $____________ Per policy period: $____________ Deductible: $____________

Please note that the proposed insurance will be effective at a date determined by the insurers.

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APPLICANT’S CONSENT TO THE TRANSMISSION OF THE INFORMATION CONTAINED IN THE APPLICATION FORM

I hereby acknowledge that the information collected in the Application form is acquired by my insurance broker to be transmitted to Victor Insurance Managers Inc. for the sole purpose of obtaining an insurance policy, and will be kept confidential.

Moreover, I authorize Victor Insurance Managers Inc., its insurers or service providers to:

- conduct verification, using outside sources, of the information contained in the Application form, in attached documentation and in subsequently provided documentation;
- in the event of a claim, transmit the submitted and verified information to loss adjusters, lawyers or other similar offices for the purposes of investigating, defending, negotiating or settling any claims, as required.

For more information on Victor’s privacy policy, please contact privacypolicyinquiries@victorinsurance.com.

DECLARATIONS AND SIGNATURE

The undersigned Applicant for this insurance declares that, to the best of their knowledge and belief, the statements set forth herein are true and correct, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application form. The undersigned agrees that, if any significant change in the condition of the Applicant is discovered between the date of this Application form and the effective date of the policy, which would render this Application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurance Manager.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant further agrees that this form and the information furnished pursuant hereto shall be the basis of the contract should a policy be issued and this form will become part of the policy.

____
Name of Applicant (please print)

______________________________	______________________________
Signature of Applicant	Date (dd/mm/yyyy)

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