**Senior Care, Long Term Care, Assisted Living and Community Housing Facilities**

**Insurance Application**

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Legal Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| SECTION 1 – GENERAL INFORMATION |

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facsimilie: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List of Subsidiaries or Related Entities (such as foundations, auxiliaries or profit-making corporations, which Control, or are Controlled by the Applicant, and for which Coverage is Required:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Type of Facility and Description of Services;

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Membership in the industry Associations(s) or Self Regulating Organizations?  Yes  No If yes, please advise

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Has your membership ever been suspended, withdrawn, amended, declined or had conditions attached?

Yes  No If yes, please provide further details.

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5. For Profit or Not-For Profit Status;

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Any Anticipated Acquisitions in the coming year?  Yes  No If yes, please explain.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Please provide your Total Gross Revenue:

For Profit

I. For the past Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

II. Estimate for the current Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not for Profit

I. For the past Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

II. Estimate for the current Financial Year: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What percentage of funds is generated from the following?

1. Government/Public \_\_\_\_\_\_\_\_\_\_\_\_\_\_%
2. Private Funding \_\_\_\_\_\_\_\_\_\_\_\_\_\_%
3. Charitable Donations \_\_\_\_\_\_\_\_\_\_\_\_\_\_%

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| SECTION 2 – PROFESSIONAL & GENERAL LIABILITY |

9.

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| Are you an Accredited Facility?  Yes  No | Identifying Accrediting Body: | Date of Last Survey: |
| Total number of Beds/Units/Apartments: | Total Number of Residents: | New Admissions per Year: |

10.

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| Number of Beds by Type/Units by Type:  General Long Term Care: Retirement: Assisted Living: Alzheimer’s Unit: Independent Living:  Respite: Palliative: Hospice: Group Home: Other: |

11. Are your patients primarily Canadian?  Yes  No

12. Do you provide care to Non-Canadian Patients?  Yes  No

Please provide percentage for Non-Canadian Patients: \_\_\_\_\_\_\_\_\_\_\_\_\_\_%

13. Do you offer Adult Day Care on your Premise to Non-Residents?  Yes  No

If yes, do you administer medication?  Yes  No

If yes, do you provide transportation?  Yes  No

If yes, do you have Alzheimer patients?  Yes  No

Daily average attendance: \_\_\_\_\_\_\_\_\_\_

14. Employees – Total Number of Employees:

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| --- | --- | --- |
| Administrator(s) \_\_\_\_\_\_ | Health Care Aids \_\_\_\_\_\_ | Social Workers \_\_\_\_\_\_ |
| Director of Care \_\_\_\_\_\_ | Maintenance Staff \_\_\_\_\_\_ | Pharmacists \_\_\_\_\_\_ |
| Medical Director \_\_\_\_\_\_ | Occupational Therapists \_\_\_\_\_\_ | Massage Therapists \_\_\_\_\_\_ |
| Other Admin Staff \_\_\_\_\_\_ | Physiotherapists \_\_\_\_\_\_ | Hairdressers \_\_\_\_\_\_ |
| RNs – General \_\_\_\_\_\_ | Chiropodists \_\_\_\_\_\_ | Recreation Therapists \_\_\_\_\_\_ |
| RN(EC) Nurse Practitioner \_\_\_\_\_\_ | Dieticians \_\_\_\_\_\_ | RPNs/LPNs \_\_\_\_\_\_ |

15. Are your Employees covered under Worker’s Compensation?  Yes  No

16. Please indicate all Procedures and or current Programs:

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| Employment Screening: |
| Use of Independent Contractors: |
| Any Volunteer Activities: |
| Procedures for Residential Admission, Ongoing Assessment: |
| Complaints: |
| Fall Prevention Program: |
| Wandering & Elopement Prevention: |
| Smoking Policy: |
| Evacuation Plan & Fire Drill: |
| Medication Administration: |
| Abuse Policy: |
| Infection Control Program: |
| Special Events & Fundraising: |
| Counseling Services: |
| Risk Management Program: |

17. Does the facility ensure and record that all Registered Medical and Dental Practitioners are members of a Medical/Dental Association/Organization and fully insured for their own Malpractice?  Yes  No

18. How are all your Patient Records stored?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. How long are your patient records stored and what type of storage medium is used?

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20. Please indicate which limit(s) and deductible(s) of Medical Professional Liability and Commercial General Liability you require quotations for:

Limits  1 Million  2 Million  3 Million  4 Million  5 Million

Deductibles  2,500  5,000  10,000

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| SECTION 3 – INSURANCE & CLAIMS HISTORY |

***\*\*\*If you are renewing your policy with AON Healthcare Advantage/Linx Underwriting Solutions, do not complete this section\*\*\****

21. Please provide current insurer information.

Name of Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Does your current policy have a Retroactive Date?  Yes  No

If yes, please provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Do you currently hold an Excess Medical Professional Liability and Commercial General Liability policy?

Yes  No If yes, please provide policy details:

Excess Limit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Has any application/policy for Medical Professional Liability or Commercial General Liability coverage ever been denied or cancelled?  Yes  No If yes, please provide details.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25. Please list all claims made against you within the last 10 years for Medical Professional Liability and Commercial General Liability or attach Loss History report. If there are no claims, please list “None”.

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| Date of  Incident | Date of  Claim | Amount  Claimed | Amount  Paid | Amount Outstanding | Claim is Open or Closed | Details including nature of allegations and claimant |
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26. Please list all fact(s) or circumstance(s) during the last 10 years that may give rise to a claim other than those already reported. Please complete below or attach on separately.

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| --- | --- |
| Date of Circumstance/Complaint | Details including nature of Complaint and of the Complainant |
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27. As per questions 25 & 26 above, have these claims been reported to your current insurer?  Yes  No

28. Please indicate which limit(s) and deductible options of Medical Professional Liability and Commercial General Liability you require quotations for:

Limit Options:  $1 Million  $2 Million  $3 Million  $4 Million  $5 Million

Deductible Options:  1,000  2,500  $5,000  $10,000

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| SECTION 4 – PRIVACY & CONSENT |

**Declarations & Warranty**

**The undersigned declares:**

The applicant(s) have reviewed all parts and attachments of this application and acknowledges that all information is true and correct and understands that this application for insurance is based on the truth and completeness of this information. Where (a) an applicant for this contract gives false information to the prejudice of the Insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein, or (b) the applicant contravenes a term of the contract or commits a fraud, or (c) the applicant willfully makes a false statement in respect of a claim, coverage may be voided by the insurer and the applicant’s right of recovery may be forfeited.

The applicant acknowledges providing personal information in this document and otherwise and may in the future provide further personal information. Some of this personal information may include, but is not limited to my credit information and claims history. I authorize my broker or insurance company to collect, use and disclose any of this personal information, subject to the law and my broker’s or insurance company’s policy regarding personal information, for the purpose of communicating with me, assessing my application for and underwriting my policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

The applicant declares that to the best of their knowledge the statements set forth herein are true. Signing of this application does not bind the Applicant or company to complete the insurance.

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| Print Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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