MED THREE INSURANCE GROUP
21 Four Seasons Place - Suite 105, Toronto, ON M9B 6J8
Main: 416-477-2353 FAX: 416-477-2399

Healthcare Program: Senior Care Renewal Application Form

SECTION 1 – GENERAL INFORMATION

Applicant (Legal Entity Name):					
Mailing Address:					
Contact:		Email:			
Telephone:		Fax:		Prior Insurer:	

Please list any subsidiary or related entities such as foundations, auxiliaries or profit-making corporations, which control, or are controlled by applicant. (Please describe function(s) of each and its relationship to the organization.)

Name of Operations	*Relationship to Applicant*	*Description of Operations*

Do you expect a Material Change in Operations in the next 12 Months?	☐ Yes ☐ No
If yes, please specify:	
Has your Organization, or owner of, had any Provincial Offences levied against them in the past year (since last application)?	☐ Yes ☐ No
What is your annual payroll?	$

SECTION 2 – PROFESSIONAL AND GENERAL LIABILITY

EMPLOYEES/ VOLUNTEERS	Has there been any changes in procedures in the past 12 months?	☐ Yes ☐ No
	If yes, please specify:	
EMPLOYMENT PRACTICES	Has there been any changes in procedures in the past 12 months?	☐ Yes ☐ No
	If yes, please specify:	
ABUSE PROTOCOLS	Have any allegations of abuse been made against you, your employees, or any other person associated with your organization during the past year? If yes, please attach details in a separate sheet of paper.	☐ Yes ☐ No
	Has there been any changes in the written policy for employees/volunteers (protocol) in the past 12 months? if yes please provide an updated copy	☐ Yes ☐ No
TRANSPORTATION	Has there been any changes in practices in the past 12 months	☐ Yes ☐ No
	If yes, please specify:	

Please Indicate the Number of Beds you are <u>Licensed</u> for:

	Retirement		Palliative Care		Alzheimer's & Dementia Unit
	Senior Assisted Living		Respite Care		Women's/Men's Shelter
	Nursing Home/Long-Term Care		Chronic Care		Adult Day Program spaces
	Independent Living/Life Lease		General Surgical		Other (please specify): spaces
	Hospice Care		Group Home		Other (please specify): spaces

Please Indicate Number of Persons Employed by your Organization (Equivalent Number of Full Time Persons):

	Management / Administrative		Personal Support Workers		Recreation/Activation Therapists
	Physicians (employed & salaried)		Kinesiologists		Social Workers / Case Workers
	Physician Assistants		Audiologist/Speech Language		Pharmacists
	Counsellors		Respiratory Therapists		Massage Therapists
	RNs-General		Physiotherapist		Housekeeping/Laundry
	RN (EC) Nurse Practitioners		Chiropodist		Cook/Food Services
	RPNs/LPNs		Acupuncturists		Hairdresser
			Dieticians / Nutritionists		Other: Please specify:

Are all staff physicians, dentists and chiropractors – NOT employed in an administrative role – members of their Mutual Defense Organization (ie, CMPA, CCMC, CCPA)?		☐ Yes ☐ No
INDEPENDENT CONTRACTORS	Do you have Independent Contractors?	☐ Yes ☐ No
	Are your Independent Contractors required to provide proof of liability insurance?	☐ Yes ☐ No

SECTION 2.1 – COVERAGE REQUIRED

What limit of Professional and General Liability Insurance do you require?	☐ $2,000,000 ☐ $5,000,000 ☐ $10,000,000 ☐ Other: $
What deductible limit do you require?	☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: $

SECTION 3 – - ADMINISTRATORS ERRORS & OMISSIONS LIABILITY

Please submit the latest financial statements and complete list of duly elected or appointed Directors and Officers of the organization

Please provide the total number of Directors and Officers in your organization:	
Is the organization in arrears in its payments of monies payable to Revenue Canada, or the provincial ministries of revenue (including source deductions, GST, PST or HST)?	☐ Yes ☐ No
Is the organization currently or has it at any time during the past twelve months been in breach of any of its debt covenants, loan agreements, contractual obligations, or does it anticipate any such breach occurring within the next 12 months?	☐ Yes ☐ No

If yes, please provide details.

SECTION 4 – COMPREHENSIVE DISHONESTY, DISAPPEARANCE AND DESTRUCTION (CRIME) INSURANCE

Total Class A (Full Time Equivalent): Note: Class A Employees are staff who have access to cash, cheques and securities in their job function.	
Has there been any changes in money handling procedures in the past 12 months?	☐ Yes ☐ No

If yes, please specify:

Usual maximum amount of cash on premises?	$
Number of employees/volunteers who would, as part of their function, visit clients in their homes	

SECTION 4.1 – COVERAGE REQUIRED

What limit of Crime Insurance do you require?	☐ $50,000 ☐ $100,000 ☐ $200,000 ☐ Other: $
What deductible limit do you require?	☐ Nil ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ Other: $

WARRANTY STATEMENT

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. The undersigned also warrants that they have not suppressed or misstated any material facts. It is further agreed by the undersigned that each policy or renewal thereof, if issued, is issued in reliance upon the truth of the representations and information in this Application.

If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned warrants he or she will immediately report such changes to the Insurer and the Insurer may modify or withdraw any quotation or agreement to bind or modify insurance.

Signing of this Application does not bind the undersigned to purchase this insurance, nor does it bind the Insurer to complete this insurance. However, should the Insurer bind and issue a policy, this Application shall serve as the basis of such contract and will be attached to and form part of the policy.

Any person who knowingly or with intent to defraud or to facilitate a fraud against any insurance company or other person submits an application or files a claim for insurance containing false, deceptive or misleading information may be guilty of insurance fraud.

IMPORTANT: **THE APPLICANT MUST SIGN THIS APPLICATION.** SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

QUEBEC AND NEW BRUNSWICK RESIDENTS ONLY:

I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language.

SIGNATURE

Signature:	(Authorized Representative)	Date (mm/dd/yyyy):	
Name (please print):		Title/Position:	

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Continuing Care/Residential Facilities Risk Management Form

RESIDENT ASSESSMENT	
Is each resident assessed upon admission to the facility?	☐ Yes ☐ No
Are there protocols for ongoing assessments of residents?	☐ Yes ☐ No
Does assessment of new residents include evaluation risk for suicide?	☐ Yes ☐ No
Do you have a Suicide Treatment or Monitoring Strategy?	☐ Yes ☐ No
Does assessment of new residents include evaluation of risk for violence?	☐ Yes ☐ No
Do all residents have their own attending physician? If no, who performs the role?	☐ Yes ☐ No
MEDICATION ADMINISTRATION	
What type of Medication Administrative System is used in your facility (e.g., unit dose, blister pack)?	
Do you employ or contract with a registered pharmacist to supervise pharmacy services?	☐ Yes ☐ No
Is there a review of residents' drug regimes on a regular basis?	☐ Yes ☐ No
Is there a system in place to track medication errors?	☐ Yes ☐ No
FALL PREVENTION	
Do you have a Fall Prevention Program?	☐ Yes ☐ No
Are fall precautions implemented based on level of risk determined by the assessment?	☐ Yes ☐ No
Does it include an assessment tool for identifying residents at risk for falls?	☐ Yes ☐ No
Are falls monitored and tracked to identify patterns or problems?	☐ Yes ☐ No
WANDERING AND ELOPEMENT PREVENTION	
Are wandering/elopement risk assessments conducted on all residents on admission?	☐ Yes ☐ No
Are Wander Guards or similar devices used as part of elopement prevention practices?	☐ Yes ☐ No
Are stairwells and exits/entrances alarmed at all times or have individual-specific electronic sensors been installed?	☐ Yes ☐ No
SKIN CARE AND DECUBITIS PREVENTION	
Are there written policies and procedures for the prevention and treatment of skin breakdown?	☐ Yes ☐ No
Are residents evaluated for skin breakdown and risk of breakdown at the time of admission?	☐ Yes ☐ No
Are skin assessments done on a regular basis?	☐ Yes ☐ No
Do you have a Wound Care Specialist?	☐ Yes ☐ No
INFECTION CONTROL	
Do you have an Infection Control Program?	☐ Yes ☐ No
Is immunization against flu offered to residents and staff annually?	☐ Yes ☐ No
Is there an Outbreak Management Plan?	☐ Yes ☐ No
Does the facility have hand hygiene protocols?	☐ Yes ☐ No
Is education and training provided to staff and volunteers on hand hygiene?	☐ Yes ☐ No
ABUSE	
Do you provide abuse prevention and awareness training to all employees and volunteers?	☐ Yes ☐ No
FIRE AND EMERGENCY PROCEDURES	
Are residents allowed to smoke inside the building?	☐ Yes ☐ No
If yes, are smoking areas supervised by a member of the staff?	☐ Yes ☐ No
Do you have an evacuation plan? Date of last evacuation exercise conducted:	☐ Yes ☐ No
Do you conduct fire drills regularly? Number per year:	☐ Yes ☐ No
Have you conducted a fire drill with the minimum of staff you will have on duty?	☐ Yes ☐ No
Do you have a fire life safety plan in place and is training conducted?	☐ Yes ☐ No
MAINTENANCE	
Do you hire independent contractors to maintain grounds? If yes, describe types:	☐ Yes ☐ No
If yes, is a Certificate of Insurance obtained from each independent contractor?	☐ Yes ☐ No

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Medical Liability / Errors and Omissions Risk Management Form

Does the governing board has a formal process for oversight of risk management which includes receipt of regular reports outlining the activities and achievements of risk management?	☐ Yes ☐ No
Are the roles and responsibilities of the committee(s) or group(s) coordinating the risk management functions (e.g., infection control, health & safety, morbidity and morality) have been explicitly stated?	☐ Yes ☐ No
Are the roles and responsibilities of the Risk Manager (or equivalent) are clearly defined?	☐ Yes ☐ No
Are the line managers risk management responsibilities are clearly defined?	☐ Yes ☐ No
Are the procedures for incident (including medication error) reporting documented, disseminated, and implemented throughout the health care organization?	☐ Yes ☐ No
Are there procedures for the compilation, completion, use, storage, and retrieval of residents' (paper/electronic) records in place and are they regularly monitored?	☐ Yes ☐ No
Do you have a procedure for managing complaints is in place?	☐ Yes ☐ No
Are the policies, procedures, protocols and guidelines reviewed at least every three years and systems exist for their dissemination to staff?	☐ Yes ☐ No
Does the facility have a communication policy which identifies the key channels of communication within and externally to the organization?	☐ Yes ☐ No
Are there formal mechanisms for the selection, recruitment, orientation and performance management of all staff?	☐ Yes ☐ No
Is there formal medical staff credentialing program which includes initial credentialing, privilege delineation, and recredentialing?	☐ Yes ☐ No
Does the organization have written policies related to health and safety, fire and security?	☐ Yes ☐ No

NOTE: Proof of compliance may be requested.

SIGNATURE

Signature:		Date (mm/dd/yyyy):	
Name (please print):		Position:	

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Community/Social Services Risk Management Form

CRISIS HOTLINES (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Do you provide a hot line? If yes, what services are provided to callers?	☐ Yes ☐ No
Do volunteers ever work the hotline without supervision?	☐ Yes ☐ No
Do you provide training to your hotline workers? If yes, specify:	☐ Yes ☐ No
Do you provide instructions in crisis counseling for situations involving suicide or rape?	☐ Yes ☐ No
CRISIS, WOMAN'S AND HOMELESS SHELTERS (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Does the shelter operate a safe home system?	☐ Yes ☐ No
Are emergency exits clearly marked and clear of obstructions?	☐ Yes ☐ No
Are shelter staff trained to deal with aggressive persons?	☐ Yes ☐ No
Does your organization take responsibility for securing a resident's personal property?	☐ Yes ☐ No
Does your organization have a protocol and procedure for evicting a resident?	☐ Yes ☐ No
Are first aid kits placed throughout the shelter?	☐ Yes ☐ No
Do members of the staff ever make decisions regarding the care of a woman's children?	☐ Yes ☐ No
Are staff members trained to recognize a battered woman's need for emergency medical assistance?	☐ Yes ☐ No
If you are running a woman's shelter, do you keep the location secret and maintain client confidentiality?	☐ Yes ☐ No
DAY CARE AND CHILD CARE (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Is the day care centre licensed by a Governmental Agency?	☐ Yes ☐ No
What is the age range of the children under your care?	☐ Yes ☐ No
Do you obtain written instructions from parents on allergic or medical problems?	☐ Yes ☐ No
Do you administer medication as directed by the parents?	☐ Yes ☐ No
Do all staff have first aid training?	☐ Yes ☐ No
Do you provide meals or snacks?	☐ Yes ☐ No
Are there any Healthcare Professionals who visit your location on a regular basis? If yes, specify:	☐ Yes ☐ No
Do you take the children on field trips? If yes, specify mode of transportation:	☐ Yes ☐ No
Do you have a policy and protocol in place for sickness or communicable diseases?	☐ Yes ☐ No
Do you have a protocol and procedure in place for child delivery and pick-up for alternate persons than the parents?	☐ Yes ☐ No
Do you have a swimming pool or is swimming ever part of your activities or field trips?	☐ Yes ☐ No
WATER TESTING/WATER MONITORING (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Is your Healthcare facility responsible for the testing of and monitoring of the local water supply?	☐ Yes ☐ No
Are the water samples collected and sent directly to Health Canada for testing?	☐ Yes ☐ No
Does your organization conduct the testing with an on site lab?	☐ Yes ☐ No
Is your Healthcare facility responsible for the implementation of any corrective measures directly to the water system should any deficiencies in the water be found?	☐ Yes ☐ No

NOTE: Proof of compliance may be requested.

SIGNATURE			
Signature:		Date (mm/dd/yyyy):	
Name (please print):		Position:	

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Schedule of Locations

APPENDIX A TO PROFESSIONAL AND GENERAL LIABILITY INSURANCE		
Location No.	**Location Address**	**Owned / Leased**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

A Healthcare and Life Sciences MGA

COMMITTED TO BROKERS

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Statement of Values

Location No.	Facility Name	Address	Occupancy	Buildings	Contents (incl. Tenant Improvements, Insured Stock, Personal Property Owned by Others)	Business Income Period of Indemnity 12 Months 24 Months *	Gross Rental Income	Total Insurable Value	Mortgages and Loss Payees Information (Name and Address)
1.				$	$	$	$	$	
2.				$	$	$	$	$	
3.				$	$	$	$	$	
4.				$	$	$	$	$	
		TOTAL:		**$**	**$**	**$**	**$**	**$**	

* Annual Income reported must be multiplied by 2

Extra Expense (Standard $500,000)	**$**

	PROTECTION				CONSTRUCTION							EQUIPMENT BREAKDOWN		
Location No.	**Sprinkler System (Y/N)**	**Fire & Burglar Alarm (Y/N)** a) Monitored b) Local c) None	**Fire Hydrant within 500 feet (Y/N)**	**Distance from Fire Hall (Km)**	**No. of Stories**	**Exterior Walls** a) Brick, Concrete, Stone b) Frame c) Brick Veneer (frame with brick exterior) d) Other (Specify)	**Roof** a) Wood b) Steel Deck c) Concrete d) Other (Specify)	**Floor** a) Concrete b) Wood c) Other (Specify)	**Approximate Square Footage**	**Year Built**	**Heating Source** a) Hot Water b) Gas c) Oil d) Other (Specify)	**Air Conditioning (Y/N)**	**Emergency Power (Y/N)**	**Boiler/ Processing Vessel that requires cert (Y/N)**
1.														
2.														
3.														
4.														

Any recent upgrades or if any Building is over 35 years of age, please advise dates and details of the following upgrades

Location No.	Heating	Plumbing	Wiring	Roof	Others	Comments
1.						
2.						
3.						
4.						

SIGNATURE

I hereby certify that the values given herein represent to the best of my knowledge and belief the cost of replacement of the property described which is to be insured on a replacement cost basis.

Signature:		Date (mm/dd/yyyy):	
Name (please print):		Position:	