INSURANCE FOR PROVIDERS OF LONG TERM CARE

MedSurance® LTC Application Form

This is an application for errors and omissions package policy aimed at providers of residential and home healthcare for the senior community. As well as errors and omissions the policy includes sexual misconduct and physical abuse liability, general liability and property. Limits are available up to $5,000,000 and worldwide cover is provided as standard. Simply complete the form and return it to your insurance broker.

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LTC

INSURANCE FOR PROVIDERS OF LONG TERM CARE

APPLICATION FORM

INTRODUCTION

The purpose of this application form is for us to find out who you are and to obtain information relevant to the cover provided by the MedSurance® LTC policy. Completion of this application form does not oblige either party to enter into a contract of insurance. Insurance is a contract of utmost good faith. This means that the information you provide in this application form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your application for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed. If a contract of insurance is agreed between you and us this application form will form the basis of the contract.

Important: Some Insuring Clauses of this Policy provide cover on a claims made basis. Under these Insuring Clauses a claim must be first made against the Insured and notified to us during the period of the policy to be covered. These Insuring Clauses do not cover any claim arising out of any actual or alleged wrongful act occurring before the Retroactive Date.

HOW TO COMPLETE THIS FORM

Whoever fills out the form must be a principal, partner or director of the applicant firm and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered. If you require any extra room to complete the answers to questions contained within this application form please continue your response in the Additional Information section at the back of the form. Once you have completed the form please return directly to your insurance broker.

SECTION 1: COMPANY DETAILS

1.1 Please state the name and address of the principal Company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal Company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form:

Insured company:

Contact name:

Address:

ZIP code:

Telephone: Email address:

Fax: Website:

1.2 Please state when your company was established: MM / DD / YY

1.3 Please state whether your company is: For profit ☐ Not for profit ☐

1.4 Please state the number of employees:

Professional: Clerical: Other:

1.5 Please state your fees received in respect of the following years (in USD):

	Last complete financial year	Estimate for current financial year	Estimate for next financial year
Domestic revenue:			
Other territory revenue:			
Total revenue:			
Profit / (Loss):			

Date of financial year end: MM / DD / YY

SECTION 2: ACTIVITIES

2.1 Please briefly describe below the nature of your business activities:
If you have a brochure, or company literature, please attach to this form.

2.2 Please provide a full breakdown of your total revenue by activity:
The total of all activities listed here should equal 100%.

	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%
	%

2.3 Please state the percentage of your services that you provide at each of the following locations:

Doctors office:	%	Hospital:	%
Skilled nursing facility:	%	Clinics:	%
Other:	%		

If other, please provide full details below:

2.4 Do you have written procedures in place to screen all employees and independent contractors for drug, alcohol and sexual abuse or other criminal activity? ☐ Yes ☐ No

If yes, please attach to this form.

If no, please explain below:

2.5 Do you have a formal written risk management program in place regarding the treatment of patients or residents in your care?

If yes, please attach to this form.

If no, please explain below:

2.6 Please provide details regarding employees and volunteers who use their personal vehicles on behalf of your organisation:

Type of usage	Number of employees with daily or weekly usage	Number of volunteers with daily or weekly usage	Is proof of personal auto insurance required?
Errands:			☐ Yes ☐ No
Other:			☐ Yes ☐ No

If other, please provide full details below:

2.7 Do you manufacture, sell, lease, repair, repackage or relabel any medical supplies or equipment? ☐ Yes ☐ No

If yes, please provide details below:

SECTION 3: FACILITY INFORMATION

Only complete this section if you require cover for Assisted Living Facilities or Independent Living Facilities.

If more than one facility is to be insured please copy this section 3 and complete for each facility:

Facility name:

Address:

ZIP code: Website:

3.1 Is the facility licensed by the government? ☐ Yes ☐ No Expiration date of licence: MM / DD / YY

3.2 Who owns the facility?

3.3 Year facility was built: YYYY

3.4 Year of last renovation or upgrade: YYYY

3.5 Number of years in operation:

3.6 Number of floors: Number of elevators: Number of separate buildings:

3.7 If more than one building, are transfers between buildings secure? ☐ Yes ☐ No

3.8 Please provide the following details on the number of beds at the facility:

Type of facility	Number of licensed beds or units	Number of occupied beds or units
Assisted Living Facility:		
Independent Living:		

3.9 Please provide the following details on the residents of the facility:

Age group	Percentage of residents	Percentage of the residents in each category who are non-ambulatory
Under 30:	%	%
30 - 60:	%	%
60 - 80:	%	%
Over 80:	%	%

3.10 Do you accept bedridden residents? ☐ Yes ☐ No

3.11 Average percentage of residents diagnosed with Alzheimer's or Dementia: %

Are residents diagnosed with Alzheimer's or Dementia housed in a specific self-contained unit? ☐ Yes ☐ No

3.12 Administrator name:

Number of years experience as an administrator: At this facility: In career:

3.13 Are medication technicians used at this facility? ☐ Yes ☐ No

If yes, are they trained in government-approved programs? ☐ Yes ☐ No

If no, please explain below:

3.14 Does the facility use contract (a.k.a. agency, registry) staff? ☐ Yes ☐ No

If yes, do you request evidence of insurance? ☐ Yes ☐ No

What percentage of all hours are provided by contact staff? %

3.15 Please provide building fire protection details, please check which of the following apply:

Common areas:	Heat detectors:		Smoke detectors:		Sprinklers:	
Hallways:	Heat detectors:		Smoke detectors:		Sprinklers:	
Resident rooms:	Heat detectors:		Smoke detectors:		Sprinklers:	

3.16 Please indicate how the fire detection system is routed:

Direct to fire dept:		Central onsite monitoring:	
Offsite monitoring:		No monitoring:	

3.17 Please indicate which of the following describes the facility's smoking policy:

Smoking permitted in designated indoor area(s):

Smoke-free building with smoking allowed in designated outdoor area(s):

No smoking allowed anywhere on the property:

3.18 Please indicate which of the following exit controls are in place:

CCTV:		Wanderguard (or equivalent):	
Observed exit:		Electronic door monitoring device:	
Alarms:			

3.19 How many elopements have occured at this facility in the last 12 months:

3.20 Do you provide new residents with a nursing assesment upon arrival? ☐ Yes ☐ No

3.21 Do you have a written emergency evacuation plan? ☐ Yes ☐ No

3.22 How many fire / evacuation drills do you conduct each year? ☐ Yes ☐ No

3.23 Do all residents have their own attending physician? ☐ Yes ☐ No

SECTION 4: STAFFING DETAILS

Only complete this section if you DO NOT require cover for Assisted Living Facilities or Independent Living Facilities.

4.1 Please show the total number of employees, hours and payroll per year of service in each category:
If you provide services in more than one province, please provide total annual hours and payroll by province, on a separate sheet.

Employee type	Number of full time employees (FTEs)	Annual hours	Annual payroll	% of FTEs who are independent contractors
				%
				%
				%
				%
				%
				%
				%
				%
				%
				%

4.2 Number of home visits completed annually:

By professional employees: ☐

By non-professional employees: ☐

4.3 Do you require insurance for work performed by independent contractors? ☐ Yes ☐ No

SECTION 5: COMMERCIAL PROPERTY AND BUSINESS INTERRUPTION INSURANCE

Only complete this section 5 if you require this cover.

5.1 Please state the address of the premises to be insured (if different from the address given earlier):

PREMISES 1

Address:

ZIP code:

PREMISES 2

Address:

ZIP code:

Please continue on a separate sheet if more than 2 premises are to be insured.

5.2 Please detail below any other party (such as a bank or building society) whose financial interest in the premises should be noted on the policy:

Name of party:

Interest of party:

Address:

ZIP code:

5.3 Are all of the premises:

a) Constructed with external walls of brick, stone or concrete and roofed with slate, tiles, concrete, metal, asbestos or any other non-combustible material? ☐ Yes ☐ No

b) Free from cracks or other signs of damage that may be due to subsidence, landslip or heave and have not previously suffered damage by any of these causes? ☐ Yes ☐ No

c) In an area free from flooding and not near the vicinity of any rivers, streams or tidal waters? ☐ Yes ☐ No

d) In a good state of repair? ☐ Yes ☐ No

e) Self contained with a lockable entrance door? ☐ Yes ☐ No

f) Protected by an intruder alarm that is subject to an annual maintenance contract? ☐ Yes ☐ No

NOTE: We may refuse to pay a claim if all of the devices for the security of your premises (including locks and the intruder alarm) are not put into full and effective operation whenever the premises are closed for business or left unattended.

g) Heated by a conventional electric, gas, oil or solid fuel heating system? ☐ Yes ☐ No

h) Fitted with electrical installations which are inspected at least every 5 years by a qualified electrician and any defect remedied? ☐ Yes ☐ No

i) Lifts, boilers, steam and pressure vessels inspected and approved to comply with all of the statutory requirements? ☐ Yes ☐ No

j) Sprinklered, either fully or partially? ☐ Yes ☐ No

NOTE: Assuming you have answered Yes to h) and i) above, it is important to keep records of all relevant inspections as we may a for evidence of these before paying a claim.

If you have answered No to any of the above questions then please give further details:

5.4 Please detail the amounts to be insured below for each premises:

NOTE: The amounts insured you state below should be the full rebuilding or replacement cost in each of the categories. If you understate these amounts you will be under-insuring and we may not pay the full amount of your claim. It is therefore essential that these amounts are as close to the true values of the insured items as possible.

ITEM	AMOUNT INSURED PREMISES 1	AMOUNT INSURED PREMISES 2
Main building:		
Landlord's fixtures & fittings and tenant improvements:		
Personal computers, printers and ancillary computer equipment at your premises:		
All other contents at your premises:		
Portable computers and associated equipment at home / away from your premises:		
All other contents at home / away from your premises:		

5.5 Please state, in respect of portable computers and associated equipment at home / away from your premises, the maximum value of any one item (not the total value of all items):

5.6 Please detail the amounts to be insured below for business interruption cover. Note that the maximum indemnity period available is 12 months. You should bear in mind how long it will take you to re-commence trading at another premises when stating the amount insured and indemnity period.

We provide our business interruption cover on a flexible first loss basis – please specify a total amount insured for business interruption cover. This amount applies regardless of whether your business interruption loss is loss of income, extra expense, or accounts receivable. This often enables a smaller total amount insured to be specified and therefore often results in a cheaper premium.

ITEM	AMOUNT INSURED	INDEMNITY PERIOD
Business Interruption Cover (flexible first loss):		

SECTION 6: PRIVACY

6.1 Please detail which of the following data types you store on your networks, or on your hosting providers' servers:

Credit / debit card details:	☐ Yes	☐ No	Medical records / health info:	☐ Yes	☐ No
Social security numbers:	☐ Yes	☐ No	Customer bank records / details:	☐ Yes	☐ No
Individual names and address:	☐ Yes	☐ No	Employee bank records / details:	☐ Yes	☐ No
E-mail addresses:	☐ Yes	☐ No	Third party trade secrets:	☐ Yes	☐ No
Credit history and ratings:	☐ Yes	☐ No	Third party corporate confidential data:	☐ Yes	☐ No

6.2 Approximately how many private individuals (including employees) do you hold sensitive data on:

6.3 Do you ensure all sensitive data (as described above) is encrypted while standing and during transmission? ☐ Yes ☐ No

SECTION 7: CLAIMS EXPERIENCE AND INSURANCE HISTORY

7.1 Please provide details of your current Errors and Omissions insurance, if applicable, and what you require for the next year of insurance:

	Retroactive date	Effective date	Limit	Deductible	Premium	Insurer
Current:	MM / YY	MM / YY				
Required:	MM / YY	MM / YY			N/A	N/A

7.2 Please provide details of your current General Liability insurance, if applicable, and what you require for the next year of insurance:

	Effective date	Limit	Deductible	Premium	Insurer
Current:	MM / YY				
Required:	MM / YY			N/A	N/A

7.3 Regarding all of the types of insurance to which this application form relates, AFTER ENQUIRY:

a) are you aware of any loss or damage, whether insured or not, that has occurred to any of the Companies to be insured (or to any existing or previous business of the partners or directors of any of the Companies to be insured) within the last 5 (five) years, or

b) are you aware of any circumstances which may give rise to a claim against any of the Companies to be insured or any partners or directors thereof, or

c) have any claims or cease and desist orders been made against any of the Companies to be insured, or partners or directors thereof, or

d) have any partners or directors of the Companies to be insured been found guilty of any criminal, dishonest or fraudulent activity or been investigated by any regulatory body?

With reference to questions a, b, c and d above: ☐ Yes ☐ No

If the answer to the above is 'Yes', then please attach full details including an explanation of the background of events, the maximum amount involved or claimed, the status of the claims or circumstances and any reserves or payments made by you or by Insurers, and the dates of all developments and payments.

SECTION 8: DECLARATION

- I declare that after proper enquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact.
- I agree that this Application Form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.
- I undertake to inform Underwriters of any material alteration to these facts occurring before the completion of the contract.

Signed: _____ Full Name: _____

Position held at Insured: _____ Date: MM / DD / YY

ADDITIONAL INFORMATION:

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