Victor Canada
500-1400 Blair Towers Place
Ottawa, Ontario K1J 9B8
Telephone 613-786-2000
Facsimile 613-786-2001
Toll Free 800-267-6684
www.victorinsurance.ca

Application

Non-Profit Entity Directors and Officers Liability and Errors and Omissions Insurance

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): _____

Note: All questions must be completed in their entirety.

GENERAL INFORMATION

1. (a) Name: _____

(b) Address: _____

_____

(c) Location of Branch Offices: _____

(d) Describe the ENTITY'S legal structure (corporation, association, foundation, professional, trade, service, etc.), purpose(s) and the nature of operations:

_____

(e) Incorporated under the laws of: _____ Incorporation Date: _____

FINANCIAL INFORMATION

2. (a) Please provide financial details of the ENTITY in the table below.

	Most Recent Year End	Previous Year End
Assets		
Liabilities		
Revenues		
Net Income (Net Loss)		

(b) Is the ENTITY in arrears in its payments of monies payable to Canada Revenue Agency or the provincial ministries of revenue (including source deductions, GST, HST and PST)? YES ☐ NO ☐

(c) Is the ENTITY currently or has it at any time during the past three years 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 ☐

(d) If the ENTITY holds a charitable status, has the status ever been revoked or been subject to review? YES ☐ NO ☐

OPERATIONAL ACTIVITIES

3. Please provide a complete description of the ENTITY'S activities and provide definitions for uncommon terms:

_____

_____

_____

_____

_____

4. To whom does the ENTITY provide services? _____

_____

5. (a) Does the ENTITY provide services or perform activities 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.

(b) Please provide a breakdown of the ENTITY'S fees by category of services:

Type of Service	% (total must be 100%)

6. (a) Please indicate areas of concern which prompted the need for errors and omissions insurance:

_____

(b) What safeguards or procedures does the ENTITY employ to avoid such losses?

_____

7. (a) Please indicate the total number of staff:

Professionals _____ Clerical _____ Volunteers _____ Other (specify) _____

(b) Please complete the following for any person performing professional activities.

Name	Duties	Education	Years of Experience

If the number of employees is greater than twenty five (25), please complete the questions in the box below.

(a) What is the annual turnover rate of employees? _____

(b) How many employees and officers have been terminated in the past two years? _____

(c) Has the turnover rate exceeded historical levels during the past two years? YES ☐ NO ☐

(d) Are any layoffs, staff reductions, or branch or office closings anticipated within the next two years? YES ☐ NO ☐

(e) Does the ENTITY have:

(i) written hiring/interviewing guidelines? YES ☐ NO ☐

(ii) a Human Resources department? (If no, please provide details.) YES ☐ NO ☐

(f) When an employee is discharged:

(i) is officer approval required? YES ☐ NO ☐

(ii) are Human Resources personnel directly involved? YES ☐ NO ☐

8. Does the ENTITY or any person(s) proposed for coverage perform the following (if yes, please explain):

(a) Take any disciplinary action or recommend disciplinary action as a result of peer review group activities? YES ☐ NO ☐

(b) Publish any magazine, periodical or newsletter (if yes, please attach a copy)? YES ☐ NO ☐

(c) Engage in activities such as lobbying or labour negotiations? YES ☐ NO ☐

IF THIS RISK INVOLVES OVERNIGHT ACCOMMODATION, PLEASE COMPLETE THE FOLLOWING:

9. Please describe your facility: _____

10. (a) Number of beds (if applicable): _____

(b) Describe type of patients: ☐ Chronic/Long-term ☐ Autonomous ☐ Physically or mentally challenged

11. Please list the name and discipline of every physician, surgeon and dentist working at the health facility and state the name of the professional liability insurer of each:

PLEASE NOTE THAT THIS PROPOSED ERRORS AND OMISSIONS INSURANCE 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.

INSURANCE INFORMATION

12. (a) Has any similar insurance to that proposed herein been cancelled or non-renewed? YES ☐ NO ☐

If yes, please provide details:

(b) Previous Directors and Officers Liability Insurance:

Insurer(s)	Period	Limit	Deductible
		$	$
		$	$
		$	$

(c) Previous Errors and Omissions Insurance:

Insurer(s)	Period	Limit	Deductible
		$	$
		$	$
		$	$

PRIOR KNOWLEDGE

13. (a) Has any claim been made or is any claim now pending against any director or officer, the ENTITY or any other person(s) proposed for coverage? YES ☐ NO ☐

(b) Has the ENTITY within the last three years been the subject of any inquiries, complaints, notices or hearings by any federal or provincial regulatory authority? YES ☐ NO ☐

(c) Is the undersigned or any other person(s) proposed for coverage aware of any fact or circumstance involving the ENTITY, its subsidiaries or the directors or officers, or the trustees, employees, volunteers or committee members of the ENTITY or its subsidiaries which he/she has reason to believe might result in any future claim? YES ☐ NO ☐

WITHOUT LIMITATION TO ANY OTHER REMEDY AVAILABLE TO THE INSURERS, THE PROPOSED INSURANCE WILL NOT AFFORD COVERAGE TO ANY CLAIMS OF WHICH ANY PERSON PROPOSED FOR COVERAGE HAS KNOWLEDGE NOR ANY CLAIMS RESULTING FROM ANY FACTS OR CIRCUMSTANCES OF WHICH ANY PERSON PROPOSED FOR COVERAGE HAS KNOWLEDGE.

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 declares that:

(a) he/she is duly authorized to complete this Application and that the statements set forth herein are true and complete;

(b) reasonable efforts have been made to obtain sufficient information from each person proposed for coverage to facilitate the proper and accurate completion of this Application form;

(c) the financial information submitted with this Application are representative of the current financial position of the ENTITY (if not, please attach details).

The undersigned agrees that:

(a) if the information supplied on this Application changes between the date of this Application and the effective date of the policy, he/she will provide written notice of such changes immediately to Victor and, without limitation to any other remedy, Victor may withdraw or modify any outstanding quotations, and any authorization or agreement to bind coverage;

(b) should a policy be issued, this Application and its attachments shall form part of the policy.

Signature	Capacity (President or Executive Director)
Date (dd/mm/yyyy)	ENTITY