PREMIER canada

APPLICANT

Legal Name of Assisted Care Facility (Applicant): ______________________________

Address: ______________________________

City: ______________ Province: ______________ Postal Code: ______________

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

Web Site Address: ______________________________

List all locations: ______________________________

Year Organization was Established: ______________________________

If this is a new organization, please attach the resume(s) of the principal(s).

Is your Organization Classified as Not for Profit? ☐ YES ☐ NO

EMPLOYEES / VOLUNTEERS

Are employment reference checks performed on all employees and volunteers? ☐ YES ☐ NO

Are criminal background checks done for all employees/volunteers? ☐ YES ☐ NO

Are new employees being asked if they are bondable? ☐ YES ☐ NO

Total Number of Employees and/or Volunteers? _____

What is the practice for training new employees? _____

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

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

If yes, please provide details: ______________________________

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

___ Physicians
___ Pharmacists
___ Nurse Practitioners
___ Physicians Assistant
___ Registered Nurses
___ Registered Practical Nurse/Nurse Aides
___ Licensed Practical Nurse/RN Assistants
___ Personal Support Workers
___ Psychologists
___ Social Workers
___ Counselors
___ Case Workers
___ Physiotherapists
___ Chiropodists
___ Kinesiologists
___ Audiologists/Speech Language
___ Respiratory Therapists
___ Register Massage Therapists
___ Chiropractors
___ Acupuncturists
___ Naturopaths
___ Occupational Therapists
___ Dieticians/Nutritionists
___ Recreation/Activation Therapists
___ Housekeeping/Laundry
___ Cook/Food Services
___ Hairdresser
___ Management/Administrative
___ Other: Please specify
____

Please indicate the Number of Beds you are Licensed for:

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

RESIDENTS/PATIENTS

Percentage of residents by age range:

_____ < 30
_____ 30-64
_____ 65-74
_____ 75-84
_____ 85-94
_____ > 95

Do you obtain written parental agreements when treating minors? ☐ YES ☐ NO

Is the Applicant engaged in any teaching? ☐ YES ☐ NO

If yes, please name the activity/discipline, total number of students(annual), and gross total fees collected (annual):

____

Accreditation:

Is the Applicant an accredited facility? ☐ YES ☐ NO

Accrediting Body: ____________________ Last Year Accreditation awarded: ____________________

Are you now or have you, within the past five years, practiced subject to any restriction or limitation imposed upon your license? ☐ YES ☐ NO

If yes, please provide details: ____________________

Have you ever been disciplined by a licensing body, or governing body? ☐ YES ☐ NO

If yes, please provide details: ____________________

CLAIMS

Has the Organization or owner, its partners, officers or employees ever had an order to cease & desist or a written demand or civil proceedings for compensatory damages made against them in the past? ☐ YES ☐ NO

If yes, please provide a full explanation on a separate sheet: such as Date of claim, Claimant's name etc.

Medical Malpractice

In the past, has the Applicant or any of his/her employees ever been the recipient of any allegations of professional negligence in writing or verbally? ☐ YES ☐ NO

Is the Applicant or any of his/her employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above? If yes, please attach details. ☐ YES ☐ NO

Without limitation of any other remedy available to the insurer, 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.

Commercial General Liability

Please detail 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.

PREVIOUS INSURANCE

Has the Applicant / Company carried Medical Malpractice Insurance in the past? ☐ YES ☐ NO

INSURER	TERM	LIMIT	PREMIUM	RETROACTIVE DATE
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

Has the Applicant ever had insurance refused or cancelled for this Company? ☐ YES ☐ NO

If yes please explain: ____________________

RISK MANAGEMENT SECTION

ABUSE PROTOCOLS

Is there a formal written policy for employees/volunteers that prohibits abuse and sexual misconduct? If yes, please attach details. ☐ YES ☐ NO

Do you have a formal written procedure for handling abuse allegations or complaints made? ☐ YES ☐ NO

Have any allegations of abuse been made against you, your employees, or any other person associated with your organization in the past? If yes, please attach details in a separate sheet of paper. ☐ YES ☐ NO

TRANSPORTATION

When transporting, does transportation include leaving your province? If yes, specify: ____________ ☐ YES ☐ NO

Do employees/volunteers drive their own vehicles on your Organization's business? ☐ YES ☐ NO

If Yes to Above:
- Do they report this use to their insurer? ☐ YES ☐ NO
- Do they carry a minimum of $1MM Auto Third Party Liability limit on their Personal Automobile policy? ☐ YES ☐ NO
- Is a certificate of insurance being requested for proof of their Automobile insurance? ☐ YES ☐ NO

FIRE LIFE SAFETY

Do you have a fire life safety plan in place and is training conducted? ☐ YES ☐ NO

Have you conducted a fire drill with the minimum of staff you will have on duty? ☐ YES ☐ NO

EMPLOYMENT PRACTICES

Do you have a current copy of the Employment Standards Act accessible for your staff? ☐ YES ☐ NO
Are written warnings given to employees to create a written record of performance issues? ☐ YES ☐ NO
Is a lawyer consulted prior to dismissing any employees? ☐ YES ☐ NO
Are all employees covered by Provincial Worker's Compensation? ☐ YES ☐ NO

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 & 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

FALL PREVENTION

Do you have a Fall Prevention Program? ☐ 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 stairwells & 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 skin assessments done on a regular basis? ☐ 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

SUB-CONTRACTED SERVICES:

What functions or facilities do you sub-contract: ____

Nursing:	☐ YES ☐ NO	Laundry:	☐ YES ☐ NO
Cleaning:	☐ YES ☐ NO	Road Maintenance:	☐ YES ☐ NO
Meal Preparation:	☐ YES ☐ NO	Landscaping/Lawn cutting:	☐ YES ☐ NO
Security:	☐ YES ☐ NO	Parking Garage or Lot Operation:	☐ YES ☐ NO
Waste Disposal:	☐ YES ☐ NO	Snow Removal:	☐ YES ☐ NO

Other: ____

If yes, please provide details: ____

INDEPENDENT CONTRACTORS / MAINTENANCE

Do you have Independent Contractors? If yes, how many? ____________ ☐ YES ☐ NO
Are your Independent Contractors required to provide proof of insurance? ☐ YES ☐ NO

MEDICAL / CARE SERVICES

Do you or any employees:

- offer Adult Day Care? If yes, please indicate number of spaces: ____________ ☐ YES ☐ NO
- administer medication? ☐ YES ☐ NO
- provide Blood Sample collection? If yes, specify: ____________ ☐ YES ☐ NO
- provide Flu Shots to Staff or Others? If Others, please specify: ____________ ☐ YES ☐ NO

Do you or any of your employees provide any manual handling/lifting services ie. Picking patients/residents up from their seats/beds etc.? ☐ YES ☐ NO
If yes, please confirm what training has been provided.

____

FIRE AND EMERGENCY PROCEDURES

Are residents allowed to smoke inside the building? If yes, are smoking areas supervised by a member of 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

COVERAGE REQUIREMENTS

Coverage	Deductible	Limit of Coverage	Target Premium
MEDICAL MALPRACTICE: claims made form, costs incl			
COMMERCIAL GENERAL LIABILITY: occurrence form -Bodily Injury & Property Damage, Products & Completed Operations, Personal Injury Liability, Medical Payments ($10,000), $100,000 Sexual Abuse Cover			
TENANT LEGAL LIABILITY: broad form ($250,000 Incl.)			
SPF6 – STANDARD NON-OWNED AUTOMOBILE:			
Optional Property Crime/Equipment Breakdown Coverage is available. Please complete Property Clinics/Care Facilities Supplemental Application.			

PLEASE READ BEFORE SIGNING: A claim will become invalid and the Insured's right of recovery is forfeited where (a) an Applicant for this contract gives false particulars 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 insured fails to inform material changes to these facts during the term of the contract; (c) the insured contravenes a term of the contract or commits a fraud; or (d) the insured willfully makes a false statement in respect of a claim.

The Applicants have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

The personal information provided in this document and in the future including, but not limited to, credit information and claims history may be collected, used and disclosed by the insured's representative or insurance company, subject to local legislation, for the purpose of communicating with the insured or their representative, assessing the application for insurance and underwriting any such 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.

NOTE: Insurance is not in effect until Premier has issued a binder or policy documents.

Applicant Name:	**Position Held:**
Applicant Signature:	**Date:**
Brokerage Email:	**Broker Name/Number**

Premier Canada Assurance Managers Ltd. is one of Canada's largest Managing Underwriting Agents. The underwriting insurance carrier varies by line of business and region - please refer to specific quote for declaration of the underwriting insurance company(s).

**** Email application and attachments to - newbizprofessional@premiergroup.ca ****

Vancouver - T 604.669.5211 F 604.669.2667 London - T 519.850.1610 F 519.850.1614