RESIDENTIAL SERVICES QUESTIONAIRE

PLEASE ANSWER ALL QUESTIONS
IF THEY DO NOT APPLY, INDICATE "N/A" - IF SPACE IS INSUFFICIENT PLEASE USE SEPARATE SHEETS

1. **Name of Applicant:**
(and all Subsidiaries) ______________________________

____

2. **Mailing Address:** ______________________________

______________________________ Website Address: ______________________________

3. How long has applicant been in business under the above name? ______________________________

4. **Description of Business Operations**: ______________________________

5. a) Describe particular problems, conditions or behavior pattern which the home deals with:

____

____

b) Any medication administered? ☐ Yes ☐ No
If Yes, please specify:

____

____

c) Are residents checked for allergies? ☐ Yes ☐ No
Are EPIPENS available for staff trained how to use them? ☐ Yes ☐ No

d) Are any abnormal psychiatric conditions catered to? ☐ Yes ☐ No
If yes, please specify:

____

____

e) **Attach copy of emergency safety procedures currently in use.**

Are the premises equipped with all required fire/smoke/detection devices and fire extinguishers? ☐ Yes ☐ No

Is there a maintenance contract in force for any alarms or fire extinguishing equipment? ☐ Yes ☐ No

f) What policies and procedures are in place to cope with medical procedures and/or emergencies?

____

____

g) Does the applicant employ any medical staff – i.e., doctors, nurses, therapists, etc? ☐ Yes ☐ No

____

6. How long has Applicant been operating? __________________ Revenue: __________________

Have any of the principals, in the past 10 years, operated another similar business? ☐ Yes ☐ No
If yes, please attach full details on a separate sheet.

7. a) Total number of:

Employees – salaried:		Employees – contracted:	
Independent Contractors:		Volunteers	
Franchises:		Franchise’s Employees	

b) Describe work performed for Applicant by independent contractors or sub-contractors:

____

____

c) Is evidence of Liability Insurance obtained from all independent contractors or sub-contractors? ☐ Yes ☐ No
If No, please explain:

____

____

If Yes, please advise what limits they are required to provide: ____________________

8. a) Does applicant have any agreements assuming liability? ☐ Yes ☐ No
If so, please describe and provide copies.

b) How many people in Applicant's care?

Children or juveniles: ______ Mentally or physically challenged adults: ______

Others: ______ ______

c) How many beds are available? ______

d) How many employees care for:

Children or juveniles ______ Mentally or physically challenged adults ______

Others ______ ______

Occupation of Employee	Professional Accreditation	Emergency Medical Training (if any)	Works With	
			Children	Adults

Are all employees covered under WSIB? ☐ Yes ☐ No
If No, please list numbers by job description and estimated payroll:

9. What procedures are followed to screen prospective employees:

☐ Check institutional references ☐ Police check

☐ Others-define: ______

10. Please indicate facilities available for residents:

Exercise/Pool ☐ Yes ☐ No T.V. Room ☐ Yes ☐ No

Games Room ☐ Yes ☐ No Other, please describe: ______________________

11. Security arrangements:

Hall monitoring ☐ Yes ☐ No Safety checks ☐ Yes ☐ No

Alarms on exits ☐ Yes ☐ No How many staff on duty or premises overnight: __________

12. a) Is food prepared by your own staff or outside caterers? ______________________

Are those responsible aware of and trained to meet special dietary requirements? ☐ Yes ☐ No

b) Are patients allowed visitors? ☐ Yes ☐ No

What policies and procedures are in place?

____

____

c) Are any field trips, medical visits or other off-premises trips undertaken? ☐ Yes ☐ No
If Yes, please describe:

____

____

d) Are patients ever unsupervised? ☐ Yes ☐ No
Please give details:

____

____

13. Does Applicant presently carry insurance? ☐ Yes ☐ No

If Yes, who is present insurer? ______________ Premium: __________ Limit: __________

Is present insurance Claims Made? ☐ Yes ☐ No If Yes, state retro date: ____________

Are they willing to renew? ☐ Yes ☐ No
If No, please explain:

____

____

Does the policy cover all operations of the Insured? ☐ Yes ☐ No
If No, please describe:

____

____

14. **Claims History:**

Include total costs from ground up for each claim, including defense costs and deductible. Include loss experience of companies which have been taken over or merged with your company.

		AMOUNT				
Date of Occurrence	**Describe Occurrence And Injury or Damage**	**Reserve**	**Paid**	**Expenses**	**Deductible**	**Status**

Are you aware of any other incidents which may result in claims against you? ☐ Yes ☐ No

If Yes, give details: ______________________________

15. **Non-Owned Automobile**

Number of employees using their cars on company business: Regularly ________ Occasionally ________

Estimated annual cost of:

hired cars ____________ cars operated under contract (Please provide details) ____________________

16. Please indicate limit(s) of liability required: ______________________________

THE UNDERSIGNED HEREBY ACKNOWLEDGES THE TRUTH OF THE STATEMENTS CONTAINED HEREIN.

I AUTHORIZE YOU TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION AS PERMITTED BY LAW, IN CONNECTION WITH YOUR COMMERCIAL INSURANCE POLICY OR A RENEWAL, EXTENSION OR VARIATION THEREOF, FOR THE PURPOSES NECESSARY TO ASSESS THE RISK, INVESTIGATE AND SETTLE CLAIMS, AND DETECT AND PREVENT FRAUD, SUCH AS CREDIT INFORMATION, AND CLAIMS HISTORY.

For purposes of the Insurance Companies Act (Canada), this document was issued in the course of Lloyd's Underwriters' insurance business in Canada.

____________________________________ ____________________________________

Signature of Applicant (authorized representative) Date

SUBMITTED BY: ____________________________________

EMAIL: ____________________________________

For contact information visit:
www.markelinternational.ca