Markel Care
Application Form

Important notice:

1. This is an Application for a contract of insurance, in which 'Applicant' or 'you / your' means the individual, company, partnership, trust, charity, establishment or association proposing for cover.

2. This Application must be completed in ink, signed and dated. All questions must be answered to enable a quotation to be given but completion does not bind you or Underwriters to enter into any contract of insurance. If space is insufficient to answer any question fully, please attach a signed continuation sheet. You should retain a copy of the completed Application (and of any other supporting information) for future reference.

3. You are recommended to request a specimen copy of the proposed policy from your insurance broker and to consider carefully the terms, conditions, limitations and exclusions applicable to the cover. The proposed insurance covers only those losses which arise from certain events discovered or claims made against the Assured during the period of insurance, as specified in the policy.

Clients
For the purpose of the Application the term 'client' means those persons taking advantage of the client services, e.g. those being looked after, undergoing treatment, being cared for etc.

This is a fillable form.
On Page 2 you will find a **CLEAR** button which will clear all fields in the document.
To move between fields, you can use your mouse to point and click or use Tab or Enter.
In the larger fields you can use Enter to create a new line. Tab will move you to the next field.
You will also see fields that are pre-formatted for numbers or dates

www.markelinternational.ca

Markel CARE Application

Please answer all questions. If they do not apply, indicate N/A

CLEAR

PART A – APPLICANT INFORMATION

(If there is insufficient space to answer a question please continue in the 'Additional Information' at the end of this Application form).

Organization Name

Contact Person

Mailing address

Postal Code

Telephone number

Email address

Website address

Type of Business — Profit ☐ Non-Profit ☐

Are you currently licensed by a Government Agency?: — Yes ☐ No ☐

Charity registration number (if applicable)

Year Established?

Proposed Effective Date — From: To:

Insured Address(es) — Is Mailing address the insured premises? Yes ☐ No ☐
If more locations, include in the Additional information section

Premises 1	**Premises 2**	**Premises 3**
Postal code:	Postal code:	Postal code:

Does the applicant currently carry insurance? (If Yes, please describe) Yes ☐ No ☐

Insurer	Premium	Limit

Has any Insurer rejected, cancelled or refused renewal of coverage for the Applicant? Yes ☐ No ☐

If Yes, please explain:

Can you confirm that neither you, nor any governor, director, council member, officer, trustee, manager or partner of the organization or any person insured or proposing for insurance has

a. been convicted, or charged but not yet tried, of any criminal offence other than an automobile offence? Yes ☐ No * ☐

b. been declared bankrupt, gone into insolvent liquidation, or been the subject of receivership or an administrative order? Yes ☐ No * ☐

* *if 'No' please provide full details:*

PART B – YOUR OPERATIONS / ACTIVITIES

(If there is insufficient space to answer a question please continue in the 'Additional Information' at the end of this Application form).

1. Please describe the aims and activities of the Organization and/or attach brochures providing this information

2. Can you confirm that there have not been any fundamental changes in the Organization's activities over the last five years? Yes ☐ No * ☐

* *if 'No' please provide full details:*

3. Please provide background details of the experience or attach resume of managers/owners of the Organization within the field of your activities:

Fundraising events

4. Do you undertake any fund-raising events? Yes * ☐ No ☐

If Yes, please provide details.

5. a. Do you undertake or provide any activities away from your premises for your clients? Yes* ☐ No ☐

If Yes, please describe

b. If so, please describe mode of transportation and supervision

PART C – FINANCIAL INFORMATION

Financial information - Incoming

6. What is the organization's total gross revenue / operating budget for:

a. current financial year (estimate)	
b. last financial year	
c. previous financial year	

7. Provide a percentage breakdown of the source of such income (ie government funding, donations, fund raising etc):

other*	
Total	$ 0

*if income is derived from 'fee-generating or professional activities' or 'other' sources please provide full details:

Financial information - Expenses

8. Provide a percentage breakdown of the use of funds (Staff, training, operational expenses, etc):

other*	
Total	0

If other, please describe

PART D – YOUR STAFF (INCLUDING VOLUNTEERS)

Employees

9. For your current financial year what is the total number of:

a.	full time employees	
b.	part time employees	
c.	volunteers*	
d.	Other (contractors, agency etc)	
	Total	0

**If you have volunteers, how many are 'active' at any one time?*

10. Which of the following methods are used in the screening and hiring process for the employees:

Application	Yes ☐	No ☐
Interview	Yes ☐	No ☐
a. Face-to-face interview	Yes ☐	No ☐
b. Phone interview	Yes ☐	No ☐
c. Interview by more than one person	Yes ☐	No ☐
d. Written set of interview questions for employees	Yes ☐	No ☐
e. Use behavioural interviewing techniques	Yes ☐	No ☐
Observation of applicant interacting with clients	Yes ☐	No ☐
A checklist of indicators for abuse potential	Yes ☐	No ☐
Other (please specify):	Yes ☐	No ☐

11. Can you confirm that all staff and volunteers working with or who might come into contact with clients (including children engaged as volunteers) or vulnerable adults undergo:

Criminal Background check?	Yes ☐	No * ☐
Federal check?	Yes ☐	No * ☐
Abuse Registry check?	Yes ☐	No * ☐
Vulnerable sector check?	Yes ☐	No * ☐

12. Can you confirm that you undertake other background checks on staff/volunteers (previous employment records, references etc) to supplement any criminal record checks that are undertaken? Yes * ☐ No ☐

* *if 'Yes' please explain what checks are undertaken; if 'No' please explain why not:*

13. **Independent Contractors** **(Provide estimated cost of work done)**

Premises and equipment repair and maintenance	
Transportation (including Children)	
Other (please describe)	

Do you require all contractors or sub-contractors to provide proof of liability insurance? Yes * ☐ No ☐

If Yes, what limit?

Qualified/Unqualified staff

(for the purpose of this question 'staff' includes volunteers as well as employees)

14. What are your usual ratios of

	Day	Night
a. staff (excluding ancillary staff) to clients		
b. qualified to unqualified staff when on duty		

complete 'night' if residential or overnight facilities

15. How many of your staff are qualified in relation to your activities and to what level?

16. Do you employ or use the services of any doctors, surgeons, physicians, prescribing nurses, midwives, dentists or anaesthetists? Yes * ☐ No ☐

* *if 'Yes' please note that it is a condition of the policy that you ensure such persons*

a. are current members of their recognised Canadian governing professional body or association (e.g. Medical Defence Union, Ontario College of Nursing etc)

b. are indemnified or insured against their professional errors, omissions, negligence or malpractice under their own insurance, indemnity or mutual defence arrangements or similar.

17.

EMPLOYEES Job Title	AGE GROUP they work with	QUALIFICATIONS (I.E., E.C.E., First Aid Training, CPR, etc)	#of Full Time	#of Part Time	# of Volunteers

Training

18. What training is provided to your staff and/or volunteers

    a. for the special needs of your service users (including, if applicable, the handling of violent or aggressive behaviours, restraining techniques and the identification of and dealing with abuse etc.?

    b. in health and safety procedures (e.g. manual handling regulations)?

    c. in the implementation of your policy and procedures (e.g. protection policies)

19. How frequent is such training provided (e.g. induction training for new staff, ongoing and 'refresher' training for existing staff)?

20. Do you keep a written record of the training provided for each staff member Yes ☐ No * ☐

    * *if 'No' please explain why not:*

21. Do you use agency staff? Yes * ☐ No ☐

    * *if 'Yes' please answer the following questions:*

    a. do you only use agencies that conduct criminal record checks and other background checks to at least the same level as yourself? Yes ☐ No * ☐

    b. do you ensure that agency staff are made fully aware of the special needs of your clients and are familiarised with your health & safety procedures? Yes ☐ No * ☐

    * *if 'No' to either of the above questions please explain why not:*

PART E – CLIENTS

22. Please indicate what age categories and how many clients currently in your care:

	N/A	Under 8	8-15	16-17	18-60	Over 60
People with physical disabilities	☐					
People with mental health problems	☐					
People with learning difficulties	☐					
People with sensory loss including dual sensory loss	☐					
Infants (up to 18 months)	☐					
Toddlers (18 months- 3 years)	☐					
Pre-School (3 – 5 years)	☐					
Jr. School (5 – 8 years)	☐					
Sr. School (9 years and older)	☐					
Are children segregated by age group?	☐	Yes ☐ No * ☐ *If No, please explain*				
Other *	☐					

* *if any clients are declared under 'other' please provide full details:*

23. Do you

		N/A	
a.	provide services for clients who:		
1.	display (or have the potential to display) challenging, aggressive or violent behaviour?	☐	Yes * ☐ No ☐
2	have a history of committing or attempting sexual offences?	☐	Yes * ☐ No ☐
3	have been the subject of sexual abuse	☐	Yes * ☐ No ☐
4	have a history of arson or attacks on persons or property?	☐	Yes * ☐ No ☐
5	have a history of alcohol, drug or substance abuse?	☐	Yes * ☐ No ☐
6	have criminal convictions or are on bail or have been excluded from school?	☐	Yes * ☐ No ☐

**** if 'Yes' to any of the above*** *can you confirm that appropriate risk assessments are in place and staff receive appropriate training to deal with such clients?* Yes ☐ No * ☐

* *if 'No' please provide full details:*

b. Provide services for people who are detained or restrained under the Mental Health Act? Yes * ☐ No ☐

** if 'Yes' please provide full details:*

c. Provide **N/A**

1 services for young people who have been the subject of sexual abuse or have sexually abused others? ☐ Yes * ☐ No ☐

2 crisis intervention services e.g. for young people who are regarded as a danger to others or themselves ☐ Yes * ☐ No ☐

3 specialist support services e.g. for young people who might otherwise be placed in secure accommodation or who have just come from secure accommodation or who have attempted to commit arson? ☐ Yes * ☐ No ☐

** if 'Yes' please provide full details:*

24. Can you confirm that you have had and maintained an up to date accident and incident book? Yes ☐ No * ☐

* *if 'No' please explain how you record such occurrences:*

Residential / Supportive / Assisted Living accommodations

25. Do you provide any residential or overnight accommodation facilities for clients? Yes * ☐ No ☐

* *if 'Yes' please answer the following questions:*

a. how many clients can you accommodate?

b. do all clients have their own room? Yes ☐ No ☐

If Yes, do the rooms lock? Yes ☐ No ☐

c. Average Length of stay ☐ Less than a year ☐ More than a year

26. Can you confirm that in the case of Residential / Supportive / Assisted Overnight clients

a. where clients do not have their own room, consideration has been given to the compatibility of those sharing rooms (including, but not limited to, age, sex, disability, behavioural and/or psychiatric history) Yes ☐ No ☐

b. where appropriate, you have signing-in/signing-out procedures in place to ensure that you are aware which of your service users are on or off the premises Yes ☐ No ☐

c. you have procedures in place (including search and confiscation) to ensure that service users

- do not smoke on the premises ☐ Yes ☐ No*
- do not have access to alcohol or drugs (other than those prescribed for medication) or other hazardous substances ☐ Yes ☐ No*

* *if 'No' please explain why not:*

27. Do you provide residential facilities for members of client's family? Yes * ☐ No ☐

* *if 'Yes' please provide details*

28. Do you provide Home Care services? Yes * ☐ No ☐

* *if 'Yes' please answer the following question:*

a. What checks do you have in place to ensure that care workers comply with your procedures and practices whilst providing home care services?

PART F – POLICIES AND PROCEDURES / PROTOCOLS

29. Can you confirm that:

a. you have a written policies and procedures/protocols to guard against abuse of your clients by any person? *(**If Yes, please attach**)* Yes ☐ No * ☐

b. you review and update your policies and procedures/protocols at least annually and when legislation requires? Yes ☐ No * ☐

c. all staff and volunteers are aware of the policy and are provided with formal training at induction and throughout the course of their employment Yes ☐ No * ☐

* *if 'No' please explain why not:*

30. In the last 12 months, have you been subject to any policies and procedures/protocols investigations which have been substantiated? Yes * ☐ No ☐

* *if 'Yes' please provide full details:*

31. Where you are responsible for client's money, you have a policy in place to monitor, record and audit such transactions at least monthly Yes ☐ No * ☐

* *if 'No' please explain why not:*

32. What are your signing-in/signing-out procedures (and, in the case of young children, your procedures for the collection of children by persons other than their custodial parent, or when parents are delayed or are otherwise unable to pick up their child)?

Drugs and medicines

33. Do you dispense prescription drugs, medicines and the like? Yes * ☐ No ☐

* if 'Yes' please answer the following questions:

Can you confirm that

a. you have procedures in place to ensure that all drugs, medicines and the like are dispensed in accordance with prescribed treatment plans and that such dispensing is fully recorded and documented? Yes ☐ No ☐

b. all drugs, medicines and the like are kept either in a

1. locked cabinet, or
2. locked room with restricted access.

and in accordance with manufacturer's recommendations Yes ☐ No * ☐

* *if 'No' please explain why not:*

34. Is there a medical questionnaire filled out regarding any allergic or other medical condition? Yes ☐ No ☐

a. If so, are written instructions obtained from parents, and will medication be administered if needed as directed? Yes ☐ No ☐

b. If so, will a written record be kept to show the time, the medication, and who administered it? Yes ☐ No ☐

Premises

35. Does Applicant have any agreements assuming liability? Yes ☐ No ☐
*If so, please **describe and provide copies***

36. Does the Applicant have a formal equipment or premises inspection and maintenance procedure? Yes ☐ No ☐

37. Describe facilities and special features (playground, swimming pool, pets, etc.):

38. Are they fully fenced or otherwise secured? Yes * ☐ No ☐

If Yes, please describe:

39. Are they at all times supervised by a staff member? Yes ☐ No * ☐

If no, please explain

40. What is the policy regarding sickness or communicable disease?

41. What procedures are employed relative to the handling of potentially harmful items? (i.e., paints, cleaning supplies, medication kept on premises, etc.)

42. What are the current safety procedures in the event of a fire?

43. Do the premises meet all Fire Department requirements? Yes ☐ No ☐

44. Where are the fire extinguishers kept?

45. Is there a maintenance agreement in place? Yes ☐ No ☐

PART G – ABUSE SPECIFIC

46. Are abuse and neglect laws reviewed with all new employees and volunteers? Yes ☐ No ☐

47. Does the organization have a designated abuse prevention committee? Yes ☐ No ☐

48. Does the organization have a written policy with regard to abuse and abuse prevention? Yes ☐ No ☐

49. Has it been reviewed and approved by legal counsel? Yes ☐ No ☐

50. Is this policy reviewed in detail with all employees, volunteers or any person acting on behalf of the Insured that have client contact? Yes ☐ No ☐

Does this policy include:

a. Requirements for reporting all incidents? Yes ☐ No ☐

b. A formal abuse response procedure? Yes ☐ No ☐

c. Detailed investigation procedures with regard to incidents or abuse? Yes ☐ No ☐

d. The requirement to report all incidents related to an actual or suspected abuse? Yes ☐ No ☐

e. The requirement that more than one person is present at all times that clients are in the organization care? Yes ☐ No ☐

f. Procedures for monitoring new employees and volunteers during client contact? Yes ☐ No ☐

51. Are all employees and volunteers trained in recognizing possible abuse? Yes ☐ No ☐

52.

Please provide us with a copy of the written procedures in place with respect to:	**Attached**	**N/A**
Prevention of abuse	☐	☐
Initial and ongoing training for employees (including seasonal and temporary workers) and volunteers	☐	☐
Investigation procedures on abuse or allegations including reporting procedures and management	☐	☐

53. How long have these procedures been in place?

54. How do you assure these procedures are understood and adhered to?

55. Who is/are responsible for the implementation of the procedures (Please state name and position)

Over the past 10 years

56. Have there been any claims or lawsuits arising from abuse made against you or any other person associated with your organization? Yes ☐ No ☐

If Yes, please provide details and describe any change to procedures adopted as a result:

57. Have there been any incidents or allegations of abuse made against your or any other person associated with your organization? Yes ☐ No ☐

If Yes, please provide details:

58. Are you aware of any facts, incidents, circumstances or allegations that may give rise to allegations, claims or lawsuits against you or any other person in your organization Yes ☐ No ☐

If Yes, please provide details:

Previous Insurance (3 Years)

59.

Insurer	Limit	Period	Claims Made	Occurrence	Premium
		to	☐	☐	
		to	☐	☐	
		to	☐	☐	

PART H – COVERAGE REQUIREMENTS

(If there is insufficient space to answer a question please continue in the 'Additional Information' at the end of this Application form).

60.

General (Operations and premises), professional and management liability	Cover needed	Indemnity Limit
General liability (Operations and Premises)	Yes ☐ No ☐	
Non-Owned Auto	Yes ☐ No ☐	
Tenants Liability	Yes ☐ No ☐	
Employee Benefits	Yes ☐ No ☐	
Employer's Liability	Yes ☐ No ☐	
Abuse	Yes ☐ No ☐	
Is the present Abuse insurance Claims Made?	Yes * ☐ No ☐	
If Yes, state retro date		
Professional liability	Yes ☐ No ☐	
Management liability	Yes ☐ No ☐	
Property		
Business Interruption	Yes ☐ No ☐	
Crime		
Claims Preparation Costs	Yes ☐ No ☐	
Computer Theft & Funds Transfer Fraud	Yes ☐ No ☐	
Customers Interest	Yes ☐ No ☐	
Employee & Volunteer Dishonesty	Yes ☐ No ☐	
Forgery or Alteration	Yes ☐ No ☐	
Money and Securities	Yes ☐ No ☐	

Additional Coverages available	Cover needed	Indemnity Limit
Cyber	Yes ☐ No ☐	
Legal Expense	Yes ☐ No ☐	

Non Owned Automobile Questions

61.	Number of employees using their cars on company business?		Regularly:	Occasionally:
62.	Estimated annual cost of	Hired Cars: $		Cars operated under contract$

Employer's Liability Questions

63.	Number of Employees:		Payroll:	
64.	Are all employees covered under WSIB?			Yes ☐ No ☐

Management liability questions

Mergers and acquisitions

Can you confirm that

65. During the last three years you have not

    a. merged with or been taken over by any other entity? Yes ☐ No * ☐

    b. acquired or disposed of any entities? Yes ☐ No * ☐

66. There are no plans presently under consideration for the merger with or take over by another company or the acquisition or disposal of any of your operations? Yes ☐ No * ☐

    * *if 'No' please provide full details:*

Status

67. Is the organization

    a. a limited liability company? Yes * ☐ No ☐

    * *if 'Yes' please provide a percentage breakdown of the shareholdings in the organization:*

    - Directors of the organization
    - members of director's families
    - financial institutions
    - other *

    * *if any shareholdings are declared under 'other' please provide full details:*

For the purpose of this question 'financial institution' is meant in its broadest sense, i.e. a bank, insurance company, venture capital company, building society, investment trust etc.

68. Does the organization have any subsidiary companies? Yes * ☐ No ☐

** if 'Yes' please answer the following question:*

Are they 100% owned by the organization? Yes ☐ No * ☐

** if 'No' please provide details and extent of the minority interest:*

69. Is the organization a subsidiary of another company Yes * ☐ No ☐

** if 'Yes' please answer the following questions:*

a. What is the name of the ultimate holding company?

b. What is the country of registration of the ultimate holding company?

Financial status

70. In respect of the organization and its subsidiaries can you confirm that

a. none have had a pre-tax loss or negative net worth (share capital plus reserves) in any of their last two complete financial years nor is a pre-tax loss or negative net worth anticipated in their current financial year

b. none are insolvent (liabilities exceed assets), in liquidation, the subject of a winding up petition or have issued notice of a meeting to consider a resolution for liquidation?

c. none are the subject of an administration order or an application for an administration order?

d. they are all able to pay their debts as they fall due?

e. they have not changed their auditors within the last two years? Yes ☐ No * ☐

** if 'No' please provide full details:*

Legal Expense Questions

71. Have you had more than one incident in the last three years that may have been claimable under the legal expense insurance coverage? Yes ☐ No ☐

If Yes, please describe

Property Coverage

72. **Statement of Values:** *for any more than 3 locations, forward location listing including COPE information*

	Loc 1	Loc 2	Loc 3
Address			
Postal Code			
Occupancy			

Values	Loc 1	Loc 2	Loc 3
Building			
Contents			
Stock			
POED			
COED			
Misc Property Floater			
Business Income			
Extra Expense			
Rent			
Ordinary Payroll			
COPE	**Loc 1**	**Loc 2**	**Loc 3**
SqFt.			
Percent Sprinklered	%	%	%
Fire Centrally Station Monitored Alarm	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Burglary Alarm	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Number of Storeys			
Age			
Updates?			
Exterior Wall Construction			
Floors Construction			
Roof Construction			
Stated Amount Co-Insurance:	Yes ☐ No ☐		
Basis of Settlement:	☐ Replacement Cost	☐ Actual Cash Value	☐ Act Cash Value on Stock
Business Income Indemnity Period:	months	Ordinary payroll:	days
Equipment Breakdown Coverage:	Yes ☐ No ☐	Earthquake Coverage:	Yes ☐ No ☐
Flood Coverage:	Yes ☐ No ☐	Sewer Backup Coverage:	Yes ☐ No ☐

Special Hazards: (Flammable liquids/heat processes/welding):

Specific Increased Extension Limits:

MORTGAGEES / LOSS PAYEES – Name and Address:

Crime Questions

73. please provide a split of your locations and employees in Canada

    a. number of locations

    b. number of employees (including working directors) and volunteers with responsibility for money and/or stock and/or accounts and/or computer systems

74. can you confirm that any consultants, contract personnel, temporary staff or volunteers are supervised and controlled by you in the same way as your own employees? Yes ☐ No * ☐

    * *if 'No' please provide full details:*

75. can you confirm that

    a. you do not use pre-signed cheques? Yes ☐ No * ☐

    b. physical stock (if you have stock) and inventory checks are carried out at least annually by persons other than those responsible for stock Yes ☐ No * ☐

    c. in respect of all persons applying for employment or volunteering Yes ☐ No * ☐
        - as a computer analyst, programmer or operator, or
        - who will be involved in the handling of money, or
        - who will have responsibility for money, books or accounts of goods

        you obtain written or verbal references to cover a minimum period of two years immediately preceding their employment or volunteering

    d. professional external auditors audit your accounts at least once a year and within six months of the financial year end, and all recommendations are acted upon Yes ☐ No * ☐

    e. the payment for goods and services are authorised by an employee/volunteer not responsible for ordering or certifying receipt of such goods or services Yes ☐ No * ☐

    f. all cheques and other bank instruments with a value of $25,000 or greater require a minimum of dual authorisation Yes ☐ No * ☐

** if 'No' please provide full details:*

PART I – LOSS HISTORY

(If there is insufficient space to answer a question please continue in the 'Additional Information' at the end of this Application form).

Claims History

76. Five year Claims History – List all claims paid or outstanding

Description of loss reserve or loss amount paid by insurer deductible paid by insured:

****Attach Insurer generated loss reports with this application. ****

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

If Yes, give details

78. within the last five years neither the organization, nor any person insured or proposing for insurance to which this Application relates

a. has any claim, prosecution, proceedings or investigations made or instigated against them whether successful or otherwise? Yes ☐ No ☐

b. has suffered any loss or made any claim (whether insured or not) which would have fallen within the scope of the proposed insurance irrespective or whether or not such loss or claim relates to the property insured or proposed for insurance? Yes ☐ No ☐

c. neither the organization nor any person insured or proposing for insurance is aware AFTER ENQUIRY, of any circumstance or incident which they have reason to suppose might afford grounds for any future claim that would fall within the scope of the expiring insurance or the proposed insurance? Yes ☐ No ☐

If Yes, give details

PART J – DECLARATION

NOTICE TO APPLICANT:

Consumer and previous insurer reports containing personal, credit, factual or investigative information about the applicant may be sought in connection with this Applicant for Insurance or any renewal, extension or variation thereof. All provisions contained in the various forms issued under this contract shall be deemed to be contained in the present Application of Insurance. The policy may be deemed to be void and claims may be denied where:

1. An Applicant for a contract;
    a. Gives false or erroneous information to the prejudice of the insurer; or
    b. Knowingly misrepresents or fails to disclose in the Application any fact required to be stated therein; or
2. The Insured contravenes a term of the Contract or commits a fraud; or
3. The Insured willfully makes a false statement in respect of a claim under the contract.

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND ACCURATE, I AM AUTHORIZED TO CONTRACT ON BEHALF OF THE INSURED, AND I APPLY FOR A CONTRACT OF INSURANCE BASED UPON THE TRUTH OF THESE STATEMENTS.

I AM IN AGREEMENT THAT THIS DECLARATION SHALL HEREBY FORM PART OF THE INSURANCE CONTRACT.

Applicant's Signature	Applicant's Position
Applicant's Name (please print)	Date

ADDITIONAL INFORMATION

Please provide additional information as requested within the Application quoting the question number to which your comments refer.

(if there is insufficient space please continue on a separate sheet and attach to this Application)

Question no.	Additional information.

NOTICE TO THE APPLICANT

The underwriters
Markel (Canada) Limited underwrites business on behalf of Markel Syndicate 3000 at Lloyd's and Markel International Insurance Company Limited.

Prior to any placement being concluded, the Applicant will be advised which insurer is to write this contract of insurance.

THE LAW OF THE INSURANCE CONTRACT
The parties to this proposed insurance are free to choose the law applicable to the insurance contract. Unless you specifically agree otherwise with Underwriters, your proposed contract will be governed by Provincial Law.