COMPLETION OF THIS FORM INDICATES YOUR CONSENT FOR PROCESSING YOUR PERSONAL INFORMATION. PLEASE REFER TO PAGE 10 FOR DETAILS ON OUR PRIVACY POLICY.

THREE Healthcare, Clinic & Allied Health New Business Application Form

Please read and complete the application in its entirety. Blanks &/or dashes are not acceptable and will delay consideration of this application. Answer all questions, if the question does not apply, indicate "N/A" in the space provided.

SECTION 1 – GENERAL INFORMATION

Applicant (Legal Entity Name):					
Mailing Address:					
Contact:		Telephone:		Fax:	
Email:		Prior Insurer(s):	Liability: Director's & Officer's:		
Organization Member:	☐ CMHA ☐ Other:		Membership No.		

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

Do you expect a Material Change in Operations in the next 12 Months?			☐ Yes ☐ No
If yes, please specify:			
When was your Organization established?		Is your Organization Classified as Not for Profit?	☐ Yes ☐ No
Do you conduct fundraising activities? If yes, please provide as separate sheet with description on planned activities			☐ Yes ☐ No
Please provide Annual Funding/Revenue (incl. Government Grants, Provincial Ministry, Fundraising, Donations, Operations)			$

SECTION 2 – GENERAL LIABILITY

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
	Is there a formal screening and orientation process for volunteers?	☐ Yes ☐ No
	Do volunteers / employees enter residences of clients?	☐ Yes ☐ No
	Are new employees being asked if they are bondable?	☐ Yes ☐ No
	Total Number of Volunteers:	
	Total number of 'Brokered Workers'. If applicable; please attach a list of names and Job description on a separate sheet of paper.	
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
TRANSPORTATION	Do you provide transportation to clients?	☐ Yes ☐ No
	Does any of this 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 the Automobile insurance?	☐ Yes ☐ No

SECTION 3 – PROFESSIONAL LIABILITY

Please Indicate what Percentage (%) of your Operations Would be Categorized as the Following (total of all 6 sections should equal 100%):

%	Category	%	Category	%	Category
______	Surgical Clinic **	______	Mental Health ***	______	Meals on Wheels
______	Medical Clinic **	______	Alcohol/Drug Addiction – Counseling	______	Adult Day Programs
______	Private or Auxiliary Hospital **	______	Alcohol/Drug Addiction – Group Home	______	Homecare Care Support
______	Rehabilitation Clinic **	______	Developmentally Delayed – Support	______	Information/Education
______	Diagnostic Imaging	______	Developmentally Delayed – Group Home	______	Community Support Services (other than above) ***
______	Cosmetic Surgery or Procedures **				
______	Hospice *	______	Homeless Shelter ***	______	Licensed Day Care *** (# of spots):
______	Palliative Care *	______	Men's Shelter ***	______	Foster Care *** (# of spots):
______	Respite Care *	______	Women's (and Children's) Shelter ***	______	Child and Family Services ***
		______	Transitional Housing*		

If you have indicated for your operations a category that is marked with an asterix '*' please complete indicated Risk Management Form:

* Continuing Care/Residential Care Risk Management Form
** Medical Liability/Errors and Omissions Risk Management Form
*** Community/Social Services Risk Management Form

If not identified above, please provide full description of operations:

Please Indicate the Number of Beds you are Licensed for:

#	Type	#	Type	#	Type
______	Hospice Care	______	General Surgical	______	Homeless Shelter
______	Palliative Care	______	Non Senior Assisted Living	______	Women's/Men's Shelter
______	Respite Care	______	Group Home	______	Other (please specify):
______	Chronic care	______	Transitional Housing		

Please Indicate Number of Salaried Persons Employed by your Organization (Equivalent Number of Full Time Persons):

#	Position	#	Position	#	Position
______	Physicians	______	Registered Practical Nurse/Nurse Aides	______	Chiropractors
______	Dentists	______	Licensed Practical Nurse/RN Assistants	______	Registered Massage Therapists
______	Anesthesiologists	______	Personal Support Workers	______	Accupuncturists
______	X-Ray Technicians	______	Psychologists	______	Naturopaths
______	Lab Technicians	______	Social Workers	______	Occupational Therapists
______	Pharmacists	______	Counsellors	______	Dieticians/Nutritionists
______	Nurse Practitioners	______	Case Workers/Managers	______	Recreation/Activation Therapists
______	Physicians Assistant	______	Physiotherapists	______	All Other *
______	First Surgical Assistants	______	Chiropodists		Other: Please specify:
______	EMT/Paramedics/Ambulance Attendants	______	Kinesiologists		
______	Midwives	______	Audiologists/Speech Language		* Food Services, Housekeeping, Maintenance, Management, Administration, etc.
______	Registered Nurses	______	Respiratory Therapists		

Question	Answer
Are your Facilities Accredited?	☐ Yes ☐ No
If yes, specify accrediting body: , Including date of last survey:	
Are all staff physicians, dentists and chiropractors – NOT employed in an administrative role – members of their Mutual Defense Organization (ie, CMPA, CMCC, CCPA)?	☐ Yes ☐ No
Annual Number of Client, Clinic or Lab Visits:	/ Year
Does your organization participate in any kind of Clinical Trial? If yes, on a separate page please provide brief details of the trials including who writes the protocols, who is the lead researcher and if they have standing within the CMPA.	☐ Yes ☐ No

	Question	Answer
INDEPENDENT CONTRACTORS	Do you have Independent Contractors?	☐ Yes ☐ No
	If yes, how many?	
	Are your Independent Contractors required to provide proof of professional liability insurance?	☐ Yes ☐ No

MEDICAL / CARE SERVICES	Do you Administer Medication?	☐ Yes ☐ No
	Does your organization participate in the Needle Exchange Program?	☐ Yes ☐ No
	Does your organization provide Auricular Acupuncture?	☐ Yes ☐ No
	Do you provide Blood Sample collection?	☐ Yes ☐ No
	If yes, specify:	
	Do your services include IV Therapy?	☐ Yes ☐ No
	Do you provide Flu Shots to Staff or Others?	☐ Yes ☐ No
	If Others, please specify:	
ABUSE PROTOCOLS	Do you provide services to developmentally delayed individuals?	☐ Yes ☐ No
	If so, how many:	
	Do you provide services to minors?	☐ Yes ☐ No
	If so, how many:	
	If yes to either above:	
	Do you provide one-on-one or overnight services to developmentally delayed individuals or minors?	☐ Yes ☐ No
	Is there a formal written policy for employees/volunteers that prohibits abuse and sexual misconduct? If yes, please attach details.	☐ Yes ☐ No
	Do you provide child and or at risk persons abuse prevention and awareness training?	☐ 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 during the past 5 years? If yes, please attach details.	☐ Yes ☐ No

SECTION 4 – DIRECTORS AND OFFICERS LIABILITY (NON-PROFIT ORGANIZATION)

Please submit the latest financial statements and provide list of duly elected or appointed Directors and Officers of the organization.

Please provide the total number of Directors and Officers in your organization:	
Is the organization in arrears in its payments of monies payable to Revenue Canada, or the provincial ministries of revenue (including source deductions, GST, PST or HST)?	☐ Yes ☐ No
Do you have any employees involved in the fiduciary responsibilities of a Pension Plan on your organization's behalf?	☐ 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?	☐ Yes ☐ No
If yes, please provide details:	
Is the organization currently or has it at any time during the past twelve months 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
If yes, please provide details:	

Please indicate if there have been any changes in the past twelve months or if you anticipate any changes in the next twelve months in the following areas: If yes, specify:	a. Operations/Service of the Organization:	☐ Yes ☐ No
	b. Subsidiaries:	☐ Yes ☐ No
	c. Number of Directors and Officers:	☐ Yes ☐ No
	d. Basis of Funding :	☐ 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.

SECTION 5 – COVERAGE REQUIRED

What limit of Professional and General Liability Insurance do you require?	☐ $5,000,000 ☐ $10,000,000 ☐ Other: $
What limit of Limited Liability Sexual Wrongdoing Insurance do you require?	☐ $250,000 / $500,000 agg. ☐ $500,000 / $500,000 agg. ☐ Other: $

What Retroactive Date do you require? (Day, Month, Year)	Professional Liability: Directors and Officers (Non-Profit Organization):
What Deductible limit do you require?	☐ $Nil ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ Other: $

SECTION 6 – COMPREHENSIVE DISHONESTY, DISAPPEARANCE AND DESTRUCTION (CRIME) INSURANCE

Total Class A (Full Time Equivalent) Note: Class A Employees are staff who have access to cash, cheques and securities in their job function.	
Are countersignatures required on all cheques?	☐ Yes ☐ No
If No, please explain Cheque Signing procedure:	
Is a cheque-signing machine used?	☐ Yes ☐ No
Is there control over blank cheques?	☐ Yes ☐ No
Are cheques pre-numbered and accounted for?	☐ Yes ☐ No
Are blank cheques locked up?	☐ Yes ☐ No
Are bank accounts reconciled by someone not authorized to deposit or withdraw?	☐ Yes ☐ No
Is an annual audit conducted by an outside agent?	☐ Yes ☐ No
If yes, specify:	
Usual maximum amount of cash on premises?	$
Number of employees/volunteers who would, as part of their function, visit clients in their homes:	
Do you have a Safe?	☐ Yes ☐ No
If yes to the above:	
Is it a Class 1 safe (Iron/steel, any thickness; combination lock)?	☐ Yes ☐ No
Is it a Class 2 safe (TL-15 UL label on the door or frame of the safe)?	☐ Yes ☐ No

Please indicate the Limits of Coverage requested:

Employee Dishonesty – Form A	☐ $50,000	☐ $100,000	☐ Other: $
Money Orders & Counterfeit Paper Currency	☐ $50,000	☐ $100,000	☐ Other: $
Depositors Forgery	☐ $50,000	☐ $100,000	☐ Other: $
Credit Card Forgery	☐ $50,000	☐ $100,000	☐ Other: $
Computer Theft & Funds Transfer Fraud	☐ $50,000	☐ $100,000	☐ Other: $
Loss Inside/Outside the Premises	☐ $10,000	☐ $ 15,000	☐ Other: $
Third Party Bonding		☐ $ 15,000	☐ $25,000

SECTION 7 – CLAIMS EXPERIENCE

Have you ever had a claim against your insurance policies? If yes, please provide loss information in a separate document, including Date of loss, Coverage, Description and amount claimed/paid. Include any negligent lawsuit even if not insured.	☐ Yes ☐ No
Are you aware of any incidents or circumstances which could potentially lead to a claim against your organization? If yes, please describe on a separate sheet.	☐ Yes ☐ No
Has your organization ever been denied insurance coverage?	☐ Yes ☐ No
If yes, please state reasons.	

NOTICE CONCERNING PERSONAL INFORMATION

By soliciting insurance from South Western Insurance Group Limited, you agree and provide consent that your personal information, including that previously collected,will be collected, processed,used,communicated, transferred and retained for the following purposes:

- the communication with underwriters;
- the evaluation of claims;
- the analysis of business results;
- the underwriting of policies;
- the detection and prevention of fraud;
- purposes required or authorized by law;

- In accordance with SWG's privacy policy available at the bottom of this application and as per our website: https://swgins.com/page/privacy.html

You can exercise your right to access your personal information in our possession, to have it rectified or to withdraw your consent by contacting us at PrivacyOfficer@swgins.com. Should you exercise your right to withdraw your consent to the communication or use of the information collected required to provide certain products or services, this would prevent South Western Insurance Group from being able to provide such products or services. Further information about South Western Insurance Group Limited personal information protection policy may be obtained by contacting our privacy officer at 416-620-6604.

WARRANTY STATEMENT

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. In the event that there is any material change in the answers given to the questions contained in this application prior to the inception of the policy, the applicant must notify the underwriters in writing and the underwriters may revoke, or effect changes to, the quotation provided. Signing of the proposal does not bind the undersigned to complete the insurance but it is agreed that this form, and any additional information/document provided in support thereof by the client and/or broker, shall be the basis of the contract should a policy be issued.

NEW BRUNSWICK RESIDENTS ONLY:

I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language.

SIGNATURE			
Signature:	(Authorized Representative)	Date (mm/dd/yyyy):	
Name (please print):		Title/Position:	

INSURANCE APPLICATION CHECKLIST	
Have you also included:	
Have you attached your most recent copy of your audited Financial Statements?	☐
If you require Property Insurance have you fully completed and signed the attached Statement of Values Form?	☐
For personnel placement agencies, please attach a copy of your protocol for background checks on all professional staff.	☐
Have you duly answered all applicable questions and signed the application?	☐

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Medical Liability / Errors and Omissions Risk Management Form

Does the governing board has a formal process for oversight of risk management which includes receipt of regular reports outlining the activities and achievements of risk management?	☐ Yes ☐ No
Are the roles and responsibilities of the committee(s) or group(s) coordinating the risk management functions (e.g., infection control, health & safety, morbidity and morality) have been explicitly stated?	☐ Yes ☐ No
Are the roles and responsibilities of the Risk Manager (or equivalent) are clearly defined?	☐ Yes ☐ No
Are the line managers risk management responsibilities are clearly defined?	☐ Yes ☐ No
Are the procedures for incident (including medication error) reporting documented, disseminated, and implemented throughout the health care organization?	☐ Yes ☐ No
Are there procedures for the compilation, completion, use, storage, and retrieval of residents' (paper/electronic) records in place and are they regularly monitored?	☐ Yes ☐ No
Do you have a procedure for managing complaints is in place?	☐ Yes ☐ No
Are the policies, procedures, protocols and guidelines reviewed at least every three years and systems exist for their dissemination to staff?	☐ Yes ☐ No
Does the facility have a communication policy which identifies the key channels of communication within and externally to the organization?	☐ Yes ☐ No
Are there formal mechanisms for the selection, recruitment, orientation and performance management of all staff?	☐ Yes ☐ No
Is there formal medical staff credentialling program which includes initial credentialling, privilege delineation, and recredentialling?	☐ Yes ☐ No
Does the organization have written policies related to health and safety, fire and security?	☐ Yes ☐ No

NOTE: Proof of compliance may be requested.

SIGNATURE			
Signature:		Date (mm/dd/yyyy):	
Name (please print):		Position:	

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Care Risk Management Form

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
Is there a system in place to track medication errors?	☐ 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
Does the facility have hand hygiene protocols?	☐ Yes ☐ No
Is education and training provided to staff and volunteers on hand hygiene?	☐ Yes ☐ No
ABUSE	
Do you provide abuse prevention and awareness training to all employees and volunteers?	☐ Yes ☐ No
FIRE AND EMERGENCY PROCEDURES	
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
Have you conducted a fire drill with the minimum of staff you will have on duty?	☐ Yes ☐ No
Do you have a fire life safety plan in place and is training conducted?	☐ Yes ☐ No
MAINTENANCE	
Do you hire independent contractors to maintain grounds? If yes, describe types:	☐ Yes ☐ No
If yes, is a Certificate of Insurance obtained from each independent contractor?	☐ Yes ☐ No

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Community/Social Services Risk Management Form

CRISIS HOTLINES (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Do you provide a hot line?	☐ Yes ☐ No
If yes, what services are provided to callers?	
Do volunteers ever work the hotline without supervision?	☐ Yes ☐ No
Do you provide training to your hotline workers? If yes, specify:	☐ Yes ☐ No
Do you provide instructions in crisis counseling for situations involving suicide or rape?	☐ Yes ☐ No
CRISIS, WOMAN'S AND HOMELESS SHELTERS (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Does the shelter operate a safe home system?	☐ Yes ☐ No
Are emergency exits clearly marked and clear of obstructions?	☐ Yes ☐ No
Are shelter staff trained to deal with aggressive persons?	☐ Yes ☐ No
Does your organization take responsibility for securing a resident's personal property?	☐ Yes ☐ No
Does your organization have a protocol and procedure for evicting a resident?	☐ Yes ☐ No
Are first aid kits placed throughout the shelter?	☐ Yes ☐ No
Do members of the staff ever make decisions regarding the care of a woman's children?	☐ Yes ☐ No
Are staff members trained to recognize a battered woman's need for emergency medical assistance?	☐ Yes ☐ No
If you are running a woman's shelter, do you keep the location secret and maintain client confidentiality?	☐ Yes ☐ No
DAY CARE AND CHILD CARE (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Is the day care centre licensed by a Governmental Agency?	☐ Yes ☐ No
What is the age range of the children under your care?	
Do you obtain written instructions from parents on allergic or medical problems?	☐ Yes ☐ No
Do you administer medication as directed by the parents?	☐ Yes ☐ No
Do all staff have first aid training?	☐ Yes ☐ No
Do you provide meals or snacks?	☐ Yes ☐ No
Are there any Healthcare Professionals who visit your location on a regular basis?	☐ Yes ☐ No
If yes, specify:	
Do you take the children on field trips? If yes, specify mode of transportation:	☐ Yes ☐ No
Do you have a policy and protocol in place for sickness or communicable diseases?	☐ Yes ☐ No
Do you have a protocol and procedure in place for child delivery and pick-up for alternate persons than the parents?	☐ Yes ☐ No
Do you have a swimming pool or is swimming ever part of your activities or field trips?	☐ Yes ☐ No
WATER TESTING/WATER MONITORING (IF NOT APPLICABLE, DO NOT COMPLETE THIS SECTION)	
Is your Healthcare facility responsible for the testing of and monitoring of the local water supply?	☐ Yes ☐ No
Are the water samples collected and sent directly to Health Canada for testing?	☐ Yes ☐ No
Does your organization conduct the testing with an on site lab?	☐ Yes ☐ No
Is your Healthcare facility responsible for the implementation of any corrective measures directly to the water system should any deficiencies in the water be found?	☐ Yes ☐ No
NOTE: Proof of compliance may be requested.	

SIGNATURE			
Signature:		Date (mm/dd/yyyy):	
Name (please print):		Position:	

Statement of Values

SECTION 8 – PROPERTY AND EQUIPMENT BREAKDOWN INSURANCE

Location No.	Facility Name	Address	Occupancy	Buildings	Contents (incl. Tenant Improvements, Insured Stock, Personal Property Owned by Others)	Business Interruption	Extra Expense	Gross Rental Income	Total Insurable Value	Mortgages and Loss Payees Information
1.				$	$	$	$	$	$	
2.				$	$	$	$	$	$	
3.				$	$	$	$	$	$	
4.				$	$	$	$	$	$	
5.				$	$	$	$	$	$	
		TOTAL:		**$**	**$**	**$**	**$**	**$**	**$**	

	PROTECTION				CONSTRUCTION							EQUIPMENT BREAKDOWN		
Location No.	**Sprinkler System (Y/N)**	**Fire & Burglar Alarm (Y/N)** a) Monitored b) Local c) None	**Fire Hydrant within 500 feet (Y/N)**	**Distance from Fire Hall (Km)**	**No. of Stories**	**Exterior Walls** a) Brick, Concrete, Stone b) Frame c) Brick Veneer (frame with brick exterior) d) Other (Specify)	**Roof** a) Wood b) Steel Deck c) Concrete d) Other (Specify)	**Floor** a) Concrete b) Wood c) Other (Specify)	**Approximate Square Footage**	**Year Built**	**Heating Source** a) Hot Water b) Gas c) Oil d) Other (Specify)	**Air Conditioning (Y/N)**	**Emergency Power (Y/N)**	**Boiler/ Processing Vessel that requires cert (Y/N)**
1.														
2.														
3.														
4.														
5.														

Any recent upgrades or if any Building is over 35 years of age, please advise dates and details of the following upgrades

Location No.	Heating	Plumbing	Wiring	Roof	Others	Comments
1.						
2.						
3.						
4.						
5.						

SIGNATURE

I hereby certify that the values given herein represent to the best of my knowledge and belief the cost of replacement of the property described which is to be insured on a replacement cost basis.

Signature:		Date (mm/dd/yyyy):	
Name (please print):		Position:	

Privacy Policy

South Western Insurance Group Limited is committed to protecting the privacy and the confidentiality of our brokers and their Insured's personal information. In order to comply with privacy legislation, we have developed this Privacy Policy. Any personally identifiable information about an Insured is considered personal information and will be treated in accordance with this Privacy Policy.

IDENTIFIED PURPOSES

South Western Group only collects, uses and discloses Personal Information for the following purposes:

- Offering and providing insurance and related products and services;
- Verifying the identity and the accuracy of personal information with government agencies, industry associations, or other Insurers;
- Analyzing, assessing and underwriting risks on a prudent basis;
- Investigating and paying claims;
- Detecting and preventing fraud or other illegal activities;
- Compiling statistics;
- Complying with the laws or the requests of law enforcement agencies or regulators.

In this Privacy Policy, the above list of Identified Purposes will be referred to as the ‘Identified Purposes'.

THIRD PARTY DISCLOSURE

South Western Insurance Group may share information about you with third party companies, permitted by law. Such disclosures may include those that South Western feels are required to provide customer service, prevent fraud, perform research or comply with the law. Recipients may include South Western’s family of insurance service companies, claims representatives, service providers, consumer reporting agencies, insurance agents and brokers, law enforcement, courts and government agencies. These parties may disclose the information to others as permitted by law.

PRIVILEGE & CONFIDENTIALITY NOTICE – Electronic Messages

Electronic mail or faxes and any files transmitted with them are confidential and may be privileged and are intended solely for the use of the individual or entity to whom they are addressed. If you have received this e-mail in error, please notify the sender immediately.

CONSENT

South Western Group relies on the following actions by our Brokers and Companies as indication of their consent from an Insured to our existing and future Personal Information practices:

- The Broker has voluntarily requested personal information from an Insured for the purpose of acquiring an insurance contract or related service or product;
- The Broker has the Insured's express consent or acknowledgement contained within a written, verbal or electronic application process;
- The Insured's consent solicited by our Companies or our Brokers is for a specified purpose;
- The Broker must provide the Insured with a copy of their privacy policy and must inform South Western Group of any withdrawal of this consent by an Insured;
- The Broker may obtain the Insured's consent through the Insured's authorized representative such as a legal guardian, agent or holder of a power of attorney.

If an Insured refuses to provide the Broker with certain Personal Information or withdraws their consent South Western Group may be unable to provide insurance coverage.

LIMITING COLLECTION AND RETENTION OF PERSONAL INFORMATION

South Western Insurance Group will only collect, use or disclose personal information that is necessary for the Identified Purposes or as required by law. We will retain personal information only as long as necessary for the fulfillment of the Identified Purposes. South Western may store certain data in jurisdictions outside of Canada and may share information with third party companies that are located outside of Canada.

ACCURACY

South Western Group requests our brokers to maintain the Insured's Personal Information as accurate, complete, and up-to-date as is necessary for the Identified Purposes.

SAFEGUARDS

South Western Group will protect the Insured's Personal Information by security safeguards appropriate to the sensitivity of the information. Safeguards will vary depending on the sensitivity, format, location and storage of the Personal Information.

ACCOUNTABILITY, OPENNESS AND ACCESS

South Western Group is responsible for all Personal Information under its control and has designated a Privacy Officer who is accountable to Senior Management for South Western's compliance with the Privacy Policy.

You may contact our Privacy Officer at PrivacyOfficer@swgins.com.

CHALLENGING COMPLIANCE

If any Broker is not satisfied with South Western's response to a privacy related inquiry or complaint, they may contact the Office of the Privacy Commissioner of Canada during business hours at 1-800-282-1376 or at www.privcom.gc.ca.

Please refer to the updated comprehensive version of privacy policy on our website: https://swgins.com/page/privacy.html