

HEALTHCARE FACILITY PROFESSIONAL AND GENERAL LIABILITY APPLICATION

FOR PURPOSES OF THE *INSURANCE COMPANIES ACT (CANADA)*, THIS DOCUMENT WAS ISSUED IN THE COURSE OF LLOYD'S UNDERWRITERS' INSURANCE BUSINESS IN CANADA.

ALL QUESTIONS MUST BE ANSWERED COMPLETELY. DO NOT LEAVE ANY SPACE BLANK. INDICATE "NONE" TO QUESTIONS WHERE THERE IS NO EXPOSURE. IF THE SPACE PROVIDED IS INSUFFICIENT TO ANSWER A QUESTION FULLY, PLEASE ATTACH DETAILS ON A SEPARATE SHEET.

1. GENERAL INFORMATION

A. Full Legal Name of Applicant: _____
(Please show complete name as you wish it to appear on the policy)

Address: _____

Website: _____

B. Please list any subsidiary or related entities (e.g. Foundation, Auxiliary, Research Organization, etc.) which are controlled by the Applicant and require coverage.

NAME OF ORGANIZATION	RELATIONSHIP TO APPLICANT	DESCRIPTION OF OPERATION	COUNTRY OF DOMICILE

Note: Separate applications may be required for additional entities to be insured.

C. Contact Details:

Administration Contact Name: _____
Telephone: () _____ e-mail: _____

Engineering Contact Name: _____
Telephone: () _____ e-mail: _____

Risk Management Contact Name: _____
Telephone: () _____ e-mail: _____

D. Annual Financial Information:

i. Current Financial Year Revenue: \$ _____ Previous Financial Year Revenue: \$ _____

ii. What percentage of revenues/funds are generated from:

Government Funding? _____ %
Private Funding? _____ %
Charitable Donations? _____ %

iii. What percentages of Patients treated are:

Canadian Residents: _____ %
Non-Canadian Residents: _____ %

iv. Total Gross Assets: \$ _____

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E. Define the type of facility:

- | | |
|---|--|
| <input type="checkbox"/> Surgical Centre: | <input type="checkbox"/> Orthopaedics
<input type="checkbox"/> Ophthalmology
<input type="checkbox"/> Plastic Surgery
<input type="checkbox"/> Gynaecology
<input type="checkbox"/> Gastro-Intestinal
<input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Diagnostic Centre: | <input type="checkbox"/> X-Ray
<input type="checkbox"/> CAT Scan
<input type="checkbox"/> MRI
<input type="checkbox"/> Blood Lab
<input type="checkbox"/> Colonoscopy
<input type="checkbox"/> Mammography
<input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Medical Clinic: | <input type="checkbox"/> Primarily General Practice
<input type="checkbox"/> (Single Physician)
<input type="checkbox"/> Multiple Physician Clinic
<input type="checkbox"/> Family Health Plan
<input type="checkbox"/> Community Health Centre
<input type="checkbox"/> Walk-In Clinic |

F. Please provide a complete description of products and services offered by the Applicant: (please attach promotional material)

G. Please provide details of any new activities or developments that are likely to occur within the next 12 months (e.g. new construction projects or new clinical programs):

H. Accreditation:

Is the Applicant an accredited facility?

YES NO

Accrediting Body: _____ Last Year Accreditation awarded: _____

2. PROFESSIONAL LIABILITY SECTION – THIS POLICY SECTION IS ON A CLAIMS MADE BASIS

A. Does the Applicant have:

- | | | |
|-----------------------------|------------------------------|-----------------------------|
| i. CAT and/or MRI scanner | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Medical Teaching Facilities | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Nursing Teaching Facilities | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Pathology Laboratory | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Counselling Services | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If YES, please specify a listing of counselling services. _____

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Other Unique Services (please list): _____

ii. If any of the above services are outsourced, is proof of adequate Professional Liability Insurance provided to the Applicant? YES NO

B. Total Number of Salaried Employees:

Physicians:	_____	Registered Nurses (RNs):	_____
Residents/Interns:	_____	Nurse Practitioners (RN [EC]):	_____
Diagnostic Technicians (X-ray, MRI, CAT):	_____	Registered Practical Nurses (RPNs):	_____
Lab/Path Technicians:	_____	Allied Health Professionals: (please list)	_____
Pharmacists:	_____	All other Employees:	_____
Physician Assistants:	_____		

C. Clinical Trials:

Does the Applicant participate in Clinical Trials? YES NO

If YES, please complete the following questions:

i. Please state for whom Clinical Research Projects are undertaken (Trial Sponsors including Pharmaceutical Company, Research Foundations, etc.): _____

ii. Do you receive full indemnity from the clinical trial sponsors? YES NO

iii. Please provide annual revenue derived from Clinical Trial activity: \$ _____

iv. Please state the number of trials during the last 12 months detailing the number of volunteers in each trial: _____

v. Please state the anticipated number of trials with which the Applicant will be involved in during the next 12 months detailing the number of volunteers in each trial: _____

vi. Informed Consent:
Do Volunteers sign an informed consent form? YES NO

If YES, please attach a copy to the application form.

Are double blind studies conducted and are volunteers clearly made aware of study format? YES NO

Do trials involve female volunteers of child-bearing age? YES NO

vii. Does the Applicant conduct any formal research, testing or experimental activities in the following categories:

Transplant	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Human Embryo Research	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Surgery	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Artificial Organ	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Obstetrics	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Genetic Engineering	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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D. If Surgical Facility:

Does the Applicant have a blood bank? YES NO

Does the Applicant undertake any testing of blood or blood products? YES NO

Is 100% of the blood or blood products secured from Canadian Blood Services? YES NO

Please state the avg. number of units of blood or blood products used by the Applicant annually: _____

Please provide details on blood storage facilities and procedures: _____

E. Has the Applicant:

i. Been involved in publishing any magazines, technical manuals, periodicals or bulletins? YES NO

ii. On behalf of its stakeholders, engaged in advertising, broadcasting or reproduction of copyright? YES NO

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iii. Been involved in activities such as political lobbying or labour negotiations? YES NO

F. Does the Applicant:

i. Act as or participate in a peer review group or committee for assessing the qualifications and performance of others? YES NO

ii. Act on or participate in a peer review group or committee for assessing the quality of products manufactured, sold, handled or distributed by others? YES NO

iii. Carry out any disciplinary action or recommend disciplinary action as a result of peer review activities? YES NO

3. GENERAL LIABILITY SECTION – THIS POLICY SECTION IS ON AN OCCURRENCE BASIS

A. Brief premises description:

NAME OF BUILDING	LOCATION	YEAR BUILT	SIZE (sq.ft.)	# OF STOREYS

Please provide details on any building refurbishment or construction activity likely to occur within the next 12 months:

B. Sub-contracted Services:

i. What functions or facilities do you sub-contract? _____

Nursing	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Laundry:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cleaning:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Road Maintenance	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Meal Preparation:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Landscaping/Lawn cutting:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Security:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Parking Garage or Lot operation:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Waste Disposal:	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

Other: _____

ii. Please describe system(s) in place to ensure that sub-contractors carry adequate insurance and that the name of the Applicant as an additional insured is added to sub-contractor's insurance: _____

iii. Do all Contracts and/or third party agreements require review and approval by senior management? YES NO

If YES, who has the functional responsibility for approval? _____

Name: _____

Title: _____

C. Emergency Preparedness:

Is the staff kept regularly apprised of fire and emergency procedures? YES NO

How many times per year are emergency training drills completed with staff? _____

If a surgical or diagnostic facility, please describe the Emergency Medical Assistance Protocol and proximity to an Emergency or Trauma Center.

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D. What fund-raising activities are planned for the upcoming 12 months: _____

E. How many volunteers are involved at the Applicant's facility _____

F. Are the Applicant's employees enrolled in the Provincial Workers' Compensation Board (WCB or equivalent?) YES NO
 If no, please provide details of alternative Employee Benefit/Disability Program: _____

G. How many employees or volunteers drive their own personal vehicles on behalf of the Hospital (other than driving to and from work)? _____

H. Does the Applicant rent vehicles for short periods of time? YES NO

I. Does the Applicant customize or modify medical equipment for patient use (e.g. orthotics, braces, etc.)? YES NO
 Estimated sales revenue: \$ _____

J. Parking Lot or Garage:
 Does the Applicant own or operate a pay-for-parking lot or garage? YES NO
 What is the total number of parking spaces operated by the Applicant? _____
 What is the total revenue from these operations? \$ _____
 What security arrangements are utilized for these operations? _____

4. RISK MANAGEMENT

Please complete the following to the best of the Applicant's knowledge at the signing of the Application:

- i. The governing body of the Applicant has a formal process for oversight of Risk Management that includes regular reports outlining the achievements of risk management. YES NO
 If YES, please provide the latest report provided to the governing body and a brief description of the internal reporting process.
- ii. Roles and responsibilities have been clearly articulated within committees or groups responsible for risk management. YES NO
- iii. Procedures for incident reporting are clearly documented, disseminated and implemented throughout the Applicant's organization. YES NO
- iv. Medical record (electronic or paper) retention is in compliance with regulatory requirements. YES NO
- v. Complaint management procedure is in place and appropriately reported to senior executives. YES NO
- vi. Formal mechanisms are in place for selection, recruitment, orientation and performance management of all employees and independent medical staff. YES NO
- vii. A formal mechanism is in place for medical staff credentialing, privilege declination and/or re-credentialing. YES NO
- viii. The Applicant is in compliance with all regulatory workplace health & safety requirements. YES NO

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- ix. The Applicant disposes of all waste in accordance with regulatory requirements. YES NO
- x. The Applicant sterilizes instruments in accordance with current best practice guidelines. YES NO
- xi. The Applicant complies with product manufacturers' guidelines with respect to single-use products, devices or equipment. YES NO

5. PRIOR INSURANCE & CLAIMS HISTORY:

A. Current Insurance Information:

COVERAGE	OCCURRENCE OR CLAIMS-MADE POLICY?	RETROACTIVE DATE (CLAIMS-MADE POLICY)	EXPIRATION DATE	CURRENT LIMIT	CURRENT DEDUCTIBLE	ANNUAL PREMIUM
Professional Liability						
General Liability						
Management Liability						

B. Claims History:

i. Please attach a claims history from your current insurer noting at least the following information:

DATE OF LOSS/INCIDENT	DATE OF CLAIM	AMOUNT CLAIMED	AMOUNT PAID	AMOUNT OUTSTANDING (RESERVE)	DETAILS INCLUDING NATURE OF ALLEGATIONS AND CLAIMANT DETAILS

ii. Is the applicant aware of any facts, incident, circumstance or complaint that may reasonably give rise to a claim against the Applicant other than that noted in the above question 1). YES NO
 If YES, please provide a listing of these in the format outlined below:

PROFESSIONAL OR GENERAL LIABILITY	DATE OF INCIDENT/CIRCUMSTANCE OR COMPLAINT	DETAILS AND FACTS (INCLUDING NATURE OF INCIDENT/CIRCUMSTANCE OR COMPLAINT AND DETAILS OF THE COMPLAINANT)

iii. a. Have all of the claims, facts, incidents, circumstances and/or complaints noted above in Questions i) and ii) been reported to previous or current insurers? YES NO

b. Have all of the claims, facts, incidents, circumstances and/or complaints noted above in Questions i) and ii) been accepted by previous or current insurers and has the Applicant received verification in writing from the previous or current insurers? YES NO

iv. Has the Applicant ever had insurance Cancelled or Non Renewed for any reason? YES NO

If insurance has been declined or cancelled, please explain: _____

v. Name and Title of Individual designated to receive all notices from Insurers:

Name: _____ Title: _____

Without limitation of any other remedy available to the Insurer, it is hereby 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.

6. COVERAGES - PLEASE INDICATE WHICH LIMIT(S) THE APPLICANT WISHES TO RECEIVE QUOTATIONS

C.

COVERAGE	\$2,000,000	\$10,000,000	\$15,000,000	\$20,000,000	DEDUCTIBLE AMOUNT:
Professional Liability (Claims-Made Form)					
General Liability (Occurrence Form)					

7. NOTICE CONCERNING PERSONAL INFORMATION

By purchasing insurance from Simmlands Insurance Services Ltd. (Simmlands), a customer provides Simmlands with his or her consent to the collection, use and disclosure of personal information, including that previously collected, for the following purposes:

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

For the purposes identified above, personal information may be disclosed to Simmlands and any affiliated companies and service providers.

Further information about Simmlands' personal information protection policy may be obtained by contacting their privacy officer at 416-408.1920.

8. WARRANTY STATEMENT

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. The undersigned also warrants that they have not suppressed or misstated any material facts.

If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned warrants he or she will immediately report such changes to the Insurer.

Signing of this Application does not bind the undersigned to purchase this insurance, nor does it bind the Insurer to complete this insurance. However, should the Insurer bind and issue a policy, this Application shall serve as the basis of such contract and will be attached to and form part of the policy.

QUEBEC 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.

SIGNED: _____
(Authorized Representative)

DATED: _____

NAME (Please Print): _____

TITLE/POSITION: _____