



# LTC

**INSURANCE FOR PROVIDERS OF LONG TERM CARE**

## **MedSurance® LTC Application Form**

This is an application for Errors and Omissions package policy aimed at providers of residential and home healthcare for the senior community. As well as Errors and Omissions the policy includes sexual misconduct and physical abuse liability, General Liability and property. Limits are available up to \$5,000,000 and worldwide cover is provided as standard. Simply complete the form and return it to your insurance broker.



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## INSURANCE FOR PROVIDERS OF LONG TERM CARE

### APPLICATION FORM

#### INTRODUCTION

The purpose of this application form is for us to find out who you are and to obtain information relevant to the cover provided by the MedSurance® LTC policy. Completion of this application form does not oblige either party to enter into a contract of insurance. Insurance is a contract of utmost good faith. This means that the information you provide in this application form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your application for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed. If a contract of insurance is agreed between you and us this application form will form the basis of the contract.

Important: Some Insuring Clauses of this Policy provide cover on a claims made basis. Under these Insuring Clauses a claim must be first made against the Insured and notified to us during the period of the policy to be covered. These Insuring Clauses do not cover any claim arising out of any actual or alleged wrongful act occurring before the Retroactive Date.

#### HOW TO COMPLETE THIS FORM

Whoever fills out the form must be a principal, partner or director of the applicant firm and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered. If you require any extra room to complete the answers to questions contained within this application form please continue your response in the Additional Information section at the back of the form. Once you have completed the form please return directly to your insurance broker.

### SECTION I: COMPANY DETAILS

- I.1 Please state the name and address of the principal Company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal Company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form:

Insured company:	
Contact name:	
Address:	
ZIP code:	
Telephone:	Email address:
Fax:	Website:

- I.2 Please state when your company was established:

- I.3 Please state whether your company is:

For profit  Not for profit

- I.4 Please state the number of employees:

Professional:

Clerical:

Other:

1.5 Please state your fees received in respect of the following years (in USD):

	Last complete financial year	Estimate for current financial year	Estimate for next financial year
Domestic revenue:	_____	_____	_____
Other territory revenue:	_____	_____	_____
Total revenue:	_____	_____	_____
Profit / (Loss):	_____	_____	_____

Date of financial year end:

## SECTION 2: ACTIVITIES

2.1 Please briefly describe below the nature of your business activities:  
*If you have a brochure, or company literature, please attach to this form.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2.2 Please provide a full breakdown of your total revenue by activity:  
*The total of all activities listed here should equal 100%.*

_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %

2.3 Please state the percentage of your services that you provide at each of the following locations:

Doctors office:	<input type="text" value=""/>	%	Hospital:	<input type="text" value=""/>	%
Skilled nursing facility:	<input type="text" value=""/>	%	Clinics:	<input type="text" value=""/>	%
Other:	<input type="text" value=""/>	%			

If 'other', please provide full details below:

<hr/> <hr/> <hr/>
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- 2.4 Do you have written procedures in place to screen all employees and independent contractors for drug, alcohol and sexual abuse or other criminal activity?  Yes  No

If 'yes', please attach to this form.

If 'no', please explain below:

<hr/> <hr/> <hr/>
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- 2.5 Do you have a formal written risk management program in place regarding the treatment of patients or residents in your care?  Yes  No

If 'yes', please attach to this form.

If 'no', please explain below:

<hr/> <hr/> <hr/>
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- 2.6 Please provide details regarding employees and volunteers who use their personal vehicles on behalf of your organisation:

Type of usage	Number of employees with daily or weekly usage	Number of volunteers with daily or weekly usage	Is proof of personal auto insurance required?	
Errands:	<hr/>	<hr/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:	<hr/>	<hr/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If 'other', please provide details:

<hr/> <hr/> <hr/>
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- 2.7 Do you manufacture, sell, lease, repair, repackage or relabel any medical supplies or equipment?  Yes  No

If 'yes', please provide details below:

<hr/> <hr/> <hr/>
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## SECTION 3: FACILITY INFORMATION

Only complete this section if you require cover for Assisted Living Facilities or Independent Living Facilities.

If more than one facility is to be insured please copy this section 3 and complete for each facility:

Facility name: _____
Address: _____ _____
ZIP code: _____ Website: _____

3.1 Is the facility licensed by the government?  Yes  No Expiration date of licence:

3.2 Who owns the facility?

3.3 Year facility was built:

3.4 Year of last renovation or upgrade:

3.5 Number of years in operation:

3.6 Number of floors:  Number of elevators:  Number of separate buildings:

3.7 If more than one building, are transfers between buildings secure?  Yes  No

3.8 Please provide the following details on the number of beds at the facility:

Type of facility	Number of licensed beds or units	Number of occupied beds or units
Assisted Living Facility:	_____	_____
Independent Living:	_____	_____

3.9 Please provide the following details on the residents of the facility:

Age group	Percentage of residents	Percentage of the residents in each category who are non-ambulatory
Under 30:	_____ %	_____ %
30 - 60:	_____ %	_____ %
60 - 80:	_____ %	_____ %
Over 80:	_____ %	_____ %

3.10 Do you accept bedridden residents?  Yes  No

3.11 Average percentage of residents diagnosed with Alzheimer's or Dementia:  %

Are residents diagnosed with Alzheimer's or Dementia housed in a specific self-contained unit?  Yes  No

3.12 Administrator name:

Number of years experience as an administrator: At this facility:

In career:

3.13 Are medication technicians used at this facility?  Yes  No

If 'yes', are they trained in government-approved programs?  Yes  No

If 'no', please explain below:

3.14 Does the facility use contract (a.k.a. agency, registry) staff?  Yes  No

If 'yes', do you request evidence of insurance?  Yes  No

What percentage of all hours are provided by contact staff?  %

3.15 Please provide building fire protection details, please check which of the following apply:

Common areas:	Heat detectors:	<input type="checkbox"/>	Smoke detectors:	<input type="checkbox"/>	Sprinklers:	<input type="checkbox"/>
Hallways:	Heat detectors:	<input type="checkbox"/>	Smoke detectors:	<input type="checkbox"/>	Sprinklers:	<input type="checkbox"/>
Resident rooms:	Heat detectors:	<input type="checkbox"/>	Smoke detectors:	<input type="checkbox"/>	Sprinklers:	<input type="checkbox"/>

3.16 Please indicate how the fire detection system is routed:

Direct to fire dept:	<input type="checkbox"/>	Central onsite monitoring:	<input type="checkbox"/>
Offsite monitoring:	<input type="checkbox"/>	No monitoring:	<input type="checkbox"/>

3.17 Please indicate which of the following describes the facility's smoking policy:

Smoking permitted in designated indoor area(s):	<input type="checkbox"/>
Smoke-free building with smoking allowed in designated outdoor area(s):	<input type="checkbox"/>
No smoking allowed anywhere on the property:	<input type="checkbox"/>

3.18 Please indicate which of the following exit controls are in place:

CCTV:	<input type="checkbox"/>	Wanderguard (or equivalent):	<input type="checkbox"/>
Observed exit:	<input type="checkbox"/>	Electronic door monitoring device:	<input type="checkbox"/>
Alarms:	<input type="checkbox"/>		

3.19 How many elopements have occurred at this facility in the last 12 months:

3.20 Do you provide new residents with a nursing assessment upon arrival?  Yes  No

3.21 Do you have a written emergency evacuation plan?  Yes  No

3.22 How many fire / evacuation drills do you conduct each year?

3.23 Do all residents have their own attending physician?  Yes  No

## SECTION 4: STAFFING DETAILS

Only complete this section if you DO NOT require cover for Assisted Living Facilities or Independent Living Facilities.

- 4.1 Please show the total number of employees, hours and payroll per year of service in each category:  
 If you provide services in more than one province, please provide total annual hours and payroll by province, on a separate sheet.

Employee type	Number of full time employees (FTEs)	Annual hours	Annual payroll	% of FTEs who are independent contractors
				%
				%
				%
				%
				%
				%
				%
				%
				%

- 4.2 Number of home visits completed annually:

By professional employees:

By non-professional employees:

- 4.3 Do you require insurance for work performed by independent contractors?  Yes  No

## SECTION 5: COMMERCIAL PROPERTY & BUSINESS INTERRUPTION INSURANCE

Only complete this section if you require this cover.

- 5.1 Please state the address of the premises to be insured (if different from the address given earlier):

<b>PREMISES 1</b>	
Address:	
	ZIP code:
<b>PREMISES 2</b>	
Address:	
	ZIP code:

Please continue on a separate sheet if more than 2 premises are to be insured.

- 5.2 Please detail below any other party (such as a bank or building society) whose financial interest in the premises should be noted on the policy:

Name of party:	
Interest of party:	
Address:	
	ZIP code:

5.3 Are all of the premises:

- a) Constructed with external walls of brick, stone or concrete and roofed with slate, tiles, concrete, metal, asbestos or any other non-combustible material?  Yes  No
- b) Free from cracks or other signs of damage that may be due to subsidence, landslip or heave and have not previously suffered damage by any of these causes?  Yes  No
- c) In an area free from flooding and not near the vicinity of any rivers, streams or tidal waters?  Yes  No
- d) In a good state of repair?  Yes  No
- e) Self contained with a lockable entrance door?  Yes  No
- f) Protected by an intruder alarm that is subject to an annual maintenance contract?  Yes  No

*NOTE: We may refuse to pay a claim if all of the devices for the security of your premises (including locks and the intruder alarm) are not put into full and effective operation whenever the premises are closed for business or left unattended.*

- g) Heated by a conventional electric, gas, oil or solid fuel heating system?  Yes  No
- h) Fitted with electrical installations which are inspected at least every 5 years by a qualified electrician and any defect remedied?  Yes  No
- i) Lifts, boilers, steam and pressure vessels inspected and approved to comply with all of the statutory requirements?  Yes  No
- j) Sprinklered, either fully or partially?  Yes  No

*NOTE: Assuming you have answered 'yes' to h) and i) above, it is important to keep records of all relevant inspections as we may a for evidence of these before paying a claim.*

If you have answered 'no' to any of the above questions then please give further details:

5.4 Please detail the amounts to be insured below for each premises:

*NOTE: The amounts insured you state below should be the full rebuilding or replacement cost in each of the categories. If you understate these amounts you will be under-insuring and we may not pay the full amount of your claim. It is therefore essential that these amounts are as close to the true values of the insured items as possible.*

ITEM	AMOUNT INSURED PREMISES 1	AMOUNT INSURED PREMISES 2
Main building:	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Landlord's fixtures & fittings and tenant improvements:	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Personal computers, printers and ancillary computer equipment at your premises:	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
All other contents at your premises:	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Portable computers and associated equipment at home / away from your premises:	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
All other contents at home / away from your premises:	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

5.5 Please state, in respect of portable computers and associated equipment at home / away from your premises, the maximum value of any one item (not the total value of all items):



5.6 Please detail the amounts to be insured below for business interruption cover. Note that the maximum indemnity period available is 12 months. You should bear in mind how long it will take you to re-commence trading at another premises when stating the amount insured and indemnity period.

We provide our business interruption cover on a 'Flexible First Loss' basis – please specify a total amount insured for business interruption cover. This amount applies regardless of whether your business interruption loss is loss of income, extra expense, or accounts receivable. This often enables a smaller total amount insured to be specified and therefore often results in a cheaper premium.

ITEM	AMOUNT INSURED	INDEMNITY PERIOD
Business Interruption Cover ('Flexible First Loss'):	_____	_____

## SECTION 6: PRIVACY

6.1 Please detail which of the following data types you store on your networks, or on your hosting providers' servers:

- |                               |                              |                             |  |                              |                             |
|-------------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Credit / debit card details:  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medical records / health info:           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Social security numbers:      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Customer bank records / details:         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Individual names and address: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Employee bank records / details:         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E-mail addresses:             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Third party trade secrets:               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Credit history and ratings:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Third party corporate confidential data: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

6.2 Approximately how many private individuals (including employees) do you hold sensitive data on:

6.3 Do you ensure all sensitive data (as described above) is encrypted while standing and during transmission?  Yes  No

## SECTION 7: CLAIMS EXPERIENCE & INSURANCE HISTORY

7.1 Please provide details of your current Errors and Omissions insurance, if applicable, and what you require for the next year of insurance:

	Retroactive date	Effective date	Limit	Deductible	Premium	Insurer
Current:	MM / YY	MM / YY	_____	_____	_____	_____
Required:	MM / YY	MM / YY	_____	_____	N/A	N/A

7.2 Please provide details of your current General Liability insurance, if applicable, and what you require for the next year of insurance:

	Effective date	Limit	Deductible	Premium	Insurer
Current:	MM / YY	_____	_____	_____	_____
Required:	MM / YY	_____	_____	N/A	N/A

7.3 Regarding all of the types of insurance to which this application form relates, AFTER ENQUIRY:

- a) are you aware of any loss or damage, whether insured or not, that has occurred to any of the Companies to be insured (or to any existing or previous business of the partners or directors of any of the Companies to be insured) within the last 5 years, or
- b) are you aware of any circumstances which may give rise to a claim against any of the Companies to be insured or any partners or directors thereof, or
- c) have any claims or cease and desist orders been made against any of the Companies to be insured, or partners or directors thereof, or
- d) have any partners or directors of the Companies to be insured been found guilty of any criminal, dishonest or fraudulent activity or been investigated by any regulatory body?

With reference to questions a, b, c and d above:       Yes       No

If the answer to the above is 'yes', then please attach full details including an explanation of the background of events, the maximum amount involved or claimed, the status of the claims or circumstances and any reserves or payments made by you or by Insurers, and the dates of all developments and payments.

## SECTION 8: DECLARATION

- I declare that after proper enquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact.
- I agree that this Application Form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.
- I undertake to inform Underwriters of any material alteration to these facts occurring before the completion of the contract.

Signed: _____	Full name: _____
Position held at insured: _____	Date: MM / DD / YY

ADDITIONAL INFORMATION:

# LTC



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