|  |  |
| --- | --- |
| logo.jpg  Insight. Experience. Commitment. | AIS Friendship Centre and Wellness Centre Application |

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Introduction / Executive Summary

|  |
| --- |
|  |

Property Section

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

|  |  |
| --- | --- |
| Name of Insured |  |

|  |  |
| --- | --- |
| **Type** | **Information / Description** |
| **Location** |  |
| **Construction** |  |
| **Building** |  |
| **Equipment** |  |
| **Stock** |  |
| **Business Interior** |  |
| **Total** |  |

|  |  |  |
| --- | --- | --- |
| **Property / Risk Insured** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Property of Every Description anywhere in Canada or the United States including in transit |  | Yes  No |
| Business Interruption – Profits |  | Yes  No |
| Indemnity Period – 12 months |  | Yes  No |
| Ordinary Payroll –       days |  | Yes  No |
| Business Interruption – Gross Earnings |  | Yes  No |
| Coinsurance 50% 80% |  | Yes  No |
| Ordinary Payroll –       days |  | Yes  No |
| Gross Rentals |  | Yes  No |
| Extra Expense |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Perils Insured** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| **Basis of Loss Settlement** | | |
| Buildings and Equipment – Replacement Cost |  | Yes  No |
| Stock – Selling Price |  | Yes  No |
| Bylaws coverage applicable to Buildings and Equipment |  | Yes  No |
| Functional Replacement Cost on EDP Equipment and Media |  | Yes  No |
| Additional Time required for rebuilding |  | Yes  No |
| All Risks of Physical Loss or Damage including Earthquake, Flood and Sewer Backup |  | Yes  No |

**Limits of Liability**

|  |  |
| --- | --- |
| Any One Occurrence |  |
|  |  |
| Annual Aggregate – Earthquake |  |
|  |  |
| Annual Aggregate – Flood |  |

**Sublimit**

Automatic Coverage – Newly Acquired Locations

|  |  |
| --- | --- |
| 90 Days Reporting |  |
|  |  |
| Not Subject to Reporting |  |
|  |  |
| Property in Transit |  |
|  |  |
| Extra Expense |  |

|  |  |
| --- | --- |
| Course of Construction |  |

|  |  |  |
| --- | --- | --- |
| **Deductibles** |  |  |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Earthquake – 3% of Values Subject to minimum |  | Yes  No |
| Earthquake – 5% of Values Subject to Minimum |  | Yes  No |
| Flood |  | Yes  No |
| ALl Other Losses |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Policy Form** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| **Manuscript Wording Including:** | | |
| Valuable Papers |  | Yes  No |
| Accounts Receivable |  | Yes  No |
| Fine Arts |  | Yes  No |
| Course of Construction |  | Yes  No |
| Debris Removal |  | Yes  No |
| Expediting Expense |  | Yes  No |
| Fire Fighting Expense |  | Yes  No |
| Consequential Damage by Service Interruption |  | Yes  No |
| Electronic Data Processing Equipment and Media Coverage (INcl. Mechanical and Electrical Breakdown) |  | Yes  No |
| Pollution Cleanup and Removal |  | Yes  No |
| per Occurrence |  | Yes  No |
| aggregate |  | Yes  No |
| Defense Costs |  | Yes  No |
| Radioactive Contamination |  | Yes  No |
| Consequential Loss |  | Yes  No |
| Professional Fees |  | Yes  No |
| Personal Effects of Employees and Officers –       per person |  | Yes  No |
| Money and Stamps |  | Yes  No |
| Lawns, Trees and Shrubs |  | Yes  No |
| Physical Damage by Civil Authority |  | Yes  No |
| Interruption by Civil Authority – 8 weeks |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Ingress/Egress – 8 weeks |  | Yes  No |
| Service Interruption |  | Yes  No |
| Contingent BI and Extra Expense including but not limited to Contributing and Recipient Premises |  | Yes  No |
| Permission for Unlimited Vacancy |  | Yes  No |
| Breach of Conditions |  | Yes  No |
| Control of Damaged Stock |  | Yes  No |
| Severability of Interest |  | Yes  No |
| Scope of Coverage |  | Yes  No |
| Errors and Omissions clause |  | Yes  No |
| Joint Loss agreement |  | Yes  No |
| Cancellation – 90 days notice |  | Yes  No |

Property Technical Information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| Location: |  | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| Date: |  | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| Inspected By: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Conferred with: |  | | | | | | | | | | |
|  |  | | | | | | | | | | |
| Number of Employees: |  | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | |
| Hours of Operation: |  | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| **Construction** |  | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| Ground Floor Area: |  | | | | | Number of Storey’s: | | | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Exterior Walls: | Concrete Block | | | | | | Concrete Panels | | | | | | Reinforced Concrete | | | | | | Concrete | | | | |
|  |  | | | | | |  | | | | | |  | | | | | |  | | | | |
| Supporting Walls: | Steel | | | | | | Wood | | | | | |  | | | | | |  | | | | |
|  |  | | | | | |  | | | | | | | |  | | | | | |
| Ground Floor: | Wood Block | | | | | | Reinforced Concrete | | | | | | | | Steel with Concrete | | | | | |
|  |  | | | | | |  | | | | | | | |  | | | | | |
| Other Floors: | Wood Block | | | | | | Reinforced Concrete | | | | | | | | Steel with Concrete | | | | | |
|  |  | | | | | |  | | | | | |  | | | | | |  | | | | |
| Roof: | Concrete | | | | | | Metal | | | | | | Steel / Wood Deck | | | | | | Wood | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | |
| Comments: |  | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | |
| Common Hazards: | Heating Systems | | | | | |  | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | |
|  | Utilities | | | | | |  | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | |
| Process Hazards: |  | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| **Protection** |  | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | Alarms Local | | | | | | Alarms Central Station | | | | | |
| Automatic Sprinklers: | | % | | | | | Yes  No | | | | | | Yes  No | | | | | |
|  | |  | |  | | | | | | | | | | | | | | | | | | |
| Burglar Protection: | | Describe: | |  | | | | | | | | | | | | | | | | | | |
|  | |  | |  | | | | | | | | | | | | | | | | | | |
| Other Fire Protection: | | Describe: | |  | | | | | | | | | | | | | | | | | | |
|  | |  | | | | |  | | |  | | | | | | | | | | | | |
| Watchman Service: | | Yes  No | | | | | Describe: | | |  | | | | | | | | | | | | |
| Portable Fire Extinguishers | | Yes  No | | | | |
|  | |  | | | | |
| Hand Hoses | | Yes  No | | | | |
|  | |  | | | | |
| Hydrants: | | Within 100 m – 350 ft | | | | | | Yes  No | | | | | | | | | | | | | | |
|  | |  | | | | | |  | | | | | | | | | | | | | | |
|  | | Comments: | | |  | | | | | | | | | | | | | | | | | |
|  | |  | | |  | | | | | | | | | | | | | | | | | |
| Water Supply | | City Mains? | | | Yes  No | | | | | | | | | | | | | | | | | |
|  | |  | | |  | | | | | | | | | | | | | | | | | |
|  | | Other? | | |  | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | |  | | | | | | | | | | | | | |
| Fire Department | | Fully Paid  Volunteer | | | | | | |  | | | | | | | | | | | | | |
|  | |  | | | | | | | |  |  | | | | | | | | |  | | |
|  | | Distance from the site (kms) | | | | | | | |  | Distance from Site (miles) | | | | | | | | |  | | |
|  | |  | | | | | | | |  |  | | | | | | | | |  | | |
|  | |  | | | | | | |  | | Distance to site (metres/feet) | | | | | | | | |  | | |
|  | |  | | | | | | |  | |  | | | | | | | | |  | | |
| Exposures: | | North: |  | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | |
|  | | South: |  | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | |
|  | | East: |  | | | | | | | | | | | | | | | | | | | |
|  | |  |  | | | | | | | | | | | | | | | | | | | |
|  | | West: |  | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | |  | |  | |  | |
| Flood Risks: | | Distance to open body of water (meters) | | | | | | | | | | | |  | | (feet) | |  | |
|  | |  | | | | | | | | | | | | | | | | | | | | |
| Additional Comments: | |  | | | | | | | | | | | | | | | | | | | | |

Estimated Property Values

|  |  |
| --- | --- |
|  |  |
| Date : |  |

Location address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Type** | **Information / Description** | **values insured** |
| Location |  |  |
| Construction |  |  |
| Building |  |  |
| Equipment |  |  |
| Stock |  |  |
| Business Interior |  |  |
| **Total** |  |  |

Location address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Type** | **Information / Description** | **values insured** |
| Location |  |  |
| Construction |  |  |
| Building |  |  |
| Equipment |  |  |
| Stock |  |  |
| Business Interior |  |  |
| **Total** |  |  |

Location address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Type** | **Information / Description** | **values insured** |
| Location |  |  |
| Construction |  |  |
| Building |  |  |
| Equipment |  |  |
| Stock |  |  |
| Business Interior |  |  |
| **Total** |  |  |

Include Office Contents and EDP Equipment / Media / Extras Expense

Property Loss History

**Summary by Policy Year : From** **To**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Year** | **Net Amount Paid (# Claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Boiler and Machinery

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Named Insured |  | | | |
|  |  | | | |
| Locations Insured |  | | | |
|  |  | | | |
| Additional Named Insured |  | | | |
|  |  | | | |
| Mailing Address |  | | | |
|  |  | | | |
| Term | From |  | To |  |

|  |  |  |
| --- | --- | --- |
| **Property Damage** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Standard Comprehensive form |  | Yes  No |
| Covering a Sudden and Accidental Breakdown of all Boilers |  | Yes  No |
| Pressure Vessels |  | Yes  No |
| Mechanical and Electrical Machinery and Apparatus |  | Yes  No |
| Excluding production Machinery |  | Yes  No |
| Also Quote Production Machinery |  | Yes  No |
| Valuation – Repair or Replacement Cost |  | Yes  No |
| Business Interruption |  | Yes  No |
| Gross Profits –Value $       24 month Period of Indemnity |  | Yes  No |
| Extra Expense – Value $       (100% First Month) |  | Yes  No |
| Any One Loss Combined Property Damage/Business Interruption |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Deductibles** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Property Damage |  | Yes  No |
| 24 Hour Waiting Period – Business Interruption |  | Yes  No |
| Extra Expense |  | Yes  No |
| Sub Limits |  | Yes  No |
| Expediting Expenses |  | Yes  No |
| Water Damage |  | Yes  No |
| Ammonia Contamination |  | Yes  No |
| PCB Contamination |  | Yes  No |
| Professional Fees |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Coverage Extensions** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Cancellation in 60 Days |  | Yes  No |
| By-Laws – Included up to Policy Limit |  | Yes  No |
| Off Premises Heat and/or Light |  | Yes  No |
| Stock at Selling Price |  | Yes  No |
| Interruption by Civil authority – up to 2 Weeks |  | Yes  No |
| Amended (in use connected, ready for use) |  | Yes  No |
| Brands/Labels |  | Yes  No |
| Boilers, Pressure Vessels, Electrical, Mechanical Machines, including/excluding Production Machines |  | Yes  No |
| Business Interruption – Profits |  | Yes  No |
| Gross Rentals |  | Yes  No |
| Extra Expense |  | Yes  No |
| Consequential Damage (no co-insurance) |  | Yes  No |
| Definition of Accident Sudden and Accidental Breakdown |  | Yes  No |
| Limits of Liability |  | Yes  No |

|  |  |
| --- | --- |
| Locations Insured : |  |
|  |  |
| Claims History : |  |

Boiler and Machinery Loss History Summary by Policy Year: From       to

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Year** | **Net $ Paid (# claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Commercial General Liability

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Named Insured |  | | | |
|  |  | | | |
| Additional Named Insured |  | | | |
|  |  | | | |
| Mailing Address |  | | | |
|  |  | | | |
| Term | From |  | To |  |

|  |  |  |
| --- | --- | --- |
| **Limits/Coverage Required** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Bodily Injury and property Damage per occurrence |  | Yes  No |
| Annual Aggregate products and Completed Operations |  | Yes  No |
| Tenant’s Legal Liability per Occurrence |  | Yes  No |
| Employee Benefits Liability per Occurrence and Aggregate |  | Yes  No |
| Incidental Medical Malpractice Liability per Occurrence |  | Yes  No |
| Advertising Liability per Occurrence |  | Yes  No |
| Non-Owned automobile per Occurrence |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Extensions** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| products/completed operations (Broad Form) |  | Yes  No |
| personal injury (Nil participation) |  | Yes  No |
| occurrence property damage |  | Yes  No |
| employer's liability (excludes U.S.A) |  | Yes  No |
| contingent employer's liability |  | Yes  No |
| employees as additional Named Insured |  | Yes  No |
| tenant's legal liability ("all risks") |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| non-owned automobile including SEF 94 ("All Perils" $50,000 limit) & 96 |  | Yes  No |
| Cross Liability |  | Yes  No |
| broad form property damage |  | Yes  No |
| medical payments ($10,000 each)  Cancellation – 90 Days |  | Yes  No |
| broad form vendor's |  | Yes  No |
| worldwide coverage |  | Yes  No |
| cancellation clause 90 days |  | Yes  No |
| Certificate Holders added as additional Insured |  | Yes  No |
| Owned and Non-Owned Watercraft |  | Yes  No |
| Blanket Contractual (Including verbal if contract within 120 days of agreement) |  | Yes  No |
| Incidental Medical Malpractice |  | Yes  No |
| Employee Benefits Liability |  | Yes  No |
| Advertising Liability |  | Yes  No |
| Fire Fighting Liability |  | Yes  No |
| Limited Pollution (IBC Form 2313) including Hostile Fire |  | Yes  No |
| Notice of loss as soon as practicable |  | Yes  No |
| Pay on behalf Insuring Agreement |  | Yes  No |
| Personal Injury includes mental anguish, shock, discrimination, humiliation, and harassment |  | Yes  No |
| Owners/Contractors Protective |  | Yes  No |
| Cross Liability/Severability of Interest |  | Yes  No |
| Automobile Exclusion amended to cover loading and unloading, maintenance and attached machinery |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Past & Present officers, executives, directors, employees, stock-holders, volunteers, social club members as Additional Insured |  | Yes  No |
| Automatic Coverage on newly acquired or created organizations |  | Yes  No |
| Blanket Contractual – Non Reporting |  | Yes  No |
| Elevator Collision |  | Yes  No |
| Watercraft up to 50 feet |  | Yes  No |
| Unintentional Errors & Omissions |  | Yes  No |
| Broad Definition of Insured including partnership and Joint Ventures |  | Yes  No |
| Broad Form Vendors |  | Yes  No |
| Worldwide Territory |  | Yes  No |
| Cancellation – 90 Days |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Deductibles** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Each Property Damage Occurrence |  | Yes  No |
| Each claim – Employee Benefits Liability |  | Yes  No |
| Each Claim – Tenants legal Liability |  | Yes  No |
| Each Claim – Legal Liability Damage to Hired autos |  | Yes  No |

Commercial General Liability Questionnaire

**GENERAL INFORMATION**

Insured Name

Address

Telephone       Agent

Agency Address

Telephone       Fax       E-mail

Policy Effective Date

1. How long has the insured been in business?

(Attach copies of latest annual report and balance sheet)

2. Is the insured a non-profit corporation?  Yes  No

If No, describe

3. Insured Website

4. Name of director

5. Business manager

6. Annual budget       Fiscal year

7. Describe the insured’s funding

8. How is the insured’s facility licensed?      (Attach copies of all licenses)

9. Describe the operations

10. Lines of business submitted?

11. Include the **following** items:

A)  Loss runs for past 5 years

B)  Hiring and screening practices

C)  Financial Statements

D)  Brochures

12. Has any insurer cancelled, declined, or refused renewal?  Yes  No

If yes, why?

13. Has any license ever been suspended or revoked?  Yes  No

If Yes, explain:

14. Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines?

Yes  No If Yes, explain:

15. Is applicant accredited by:

JCAHO  CARF  COA  Other:

16. List all association memberships or affiliations:

**Part I**  **Social Services**

*Section 1)* **Premises/Operations Information**

**A) Facility operated by Applicant:**  Owned by Applicant  Leased by Applicant

If owned does Applicant lease out any portion of the facility to tenants?  Yes  No

If Yes, describe occupancy of the tenants, including type of operations:

If Yes, are tenants required to carry liability insurance for their occupancy?  Yes  No

If Yes, what is the minimum liability limit Applicant requires of the tenant? $

Is Applicant always added as an Additional Insured to the tenant’s liability policy?  Yes  No

Built in:       Square Footage:      Sq. Ft. Total Number Floors:

Construction of building:  Frame  Brick  Non-Combustible  Fire Resistive

Does Applicant provide transportation to Clients?  Yes  No

**B) Protective Devices/Safety Information**

Automatic Sprinklers  Yes  No

Heat Sensors  Yes  No

Smoke Detectors  Yes  No

If Yes, does each room and hallway have a smoke detector?  Yes  No

If Yes, smoke detectors are  Electronic  Battery Operated

Fire Extinguishers  Yes  No If Yes, how many on the premises?

Fire Escapes  Yes  No If Yes, how many on the premises?

Fire Alarms  Yes  No If Yes:  Central Station  Local Alarm  None

Distance to nearest fire station?      Distance to nearest fire hydrant?

Does Applicant have a written emergency evacuation plan?  Yes  No

Are there sign in/sign out procedures in place for  Clients  Staff  Visitors

Type of security provided for the protection of your clients?  Guards  Video surveillance  Other

Are there procedures to monitor client/staff activities?  Yes  No

What preventive measures are taken to avoid clients from entering non-permitted areas of the facility?

Does insured have procedures for staff to report any incidents including meetings to discuss such incidents to safeguard location  Yes  No

**C) Swimming Pools**

Does the Applicant utilize swimming facilities?  Yes  No

If Yes:  On Premises  Off Premises Minimum age allowed in water:

If No, does Applicant anticipate using swimming facilities in the future?  Yes  No

If Yes, Explain

Are pools used exclusively for Clients?  Yes  No

If No, Explain

Does the pool have a diving board?  Yes  No Does the pool have a slide?  Yes  No

Are pool depths marked?  Yes  No Is the pool area fenced?  Yes  No

Is there a self-locking gate?  Yes  No Is supervision adequate?  Yes  No

Are Lifeguards on duty at all times when Clients are using the pools?  Yes  No

Are all Lifeguards certified?  Yes  No

Is the walking surface around pool in good condition?  Yes  No

**D) Contractors Liability**

Does the Applicant contemplate any construction activity in the next year?  Yes  No

If Yes, describe planned construction activity and estimated contract costs:

**E) Products/Completed Operations**

Does the Applicant sell goods or services to members of the public (other than to Clients)  Yes  No

**Types of Products:**

Annual Receipts: $

**Types of Services:**      

Annual Receipts: $

*Section 2)* **Special Fund Raising / Sports Events**  *Does not apply*

1. Name of Applicant:

2. Producer:

3. Name of Additional Insured(s):

4. Their Interest:

5. List Date(s) of Event(s):

6. List Location(s) of Event(s):

7. Description of Event(s) (Use additional space if necessary):

8. Describe Security Protection:

9. Seating Capacity:       Type of Seats:

10. Number of Grandstands (if any):       Permanent:       or Temporary:

11. Estimated Attendance:       Ticket Price:

12. Estimated gross receipts:

13. Number of teams:       Number of players per team:

14. Number of games played:       Duration of season/meet:

15. Age range:       to       Applicants ratio of supervisors to children:       to

16. Is contractual required?  Yes  No (If Yes, enclose a copy of the agreement)

17. Has/Have similar events been held in the past?  Yes  No

18. Any alcoholic beverages being served at the event?  Yes  No

If yes, who is serving?

19. Additional Insured Interest being required?  Yes  No

20. Total number of events expected during the year:

*Section 3)* **Sexual Misconduct**  *Does not apply*

**Current Limits:** **Occurrence / Aggregate**

1. What is the age group of clients?

2. What is the ratio of staff to clients?

3. Is there more than one person responsible for the welfare of any single client?  Yes  No

If Yes, please describe:

4. Are there rules or guidelines prohibiting closed door one-on-one meetings?  Yes  No

If No, describe why unnecessary:

5. Are there written complaint procedures and are they displayed prominently?  Yes  No

If No, describe why unnecessary:

6. Do you have written formal hiring procedures? (If Yes, please submit written procedures)  Yes  No

a. How are employees screened?

b. Are at least three references secured on all prospective employees?  Yes  No

c. Are prospective employees checked with the Child Abuse Register and with law enforcement agencies for

criminal records?  Yes  No

If No, please describe steps taken to ensure that these individuals are suited for job responsibilities:

d. Has any current employee refused to be fingerprinted and checked with law enforcement

agencies?  Yes  No

7. Do all employees meet the minimum mandated educational or professional experience level for the position

assigned?  Yes  No If No, please explain:

8. Do volunteers work directly with clients?  Yes  No

9. Have any employees been the subject of a child abuse/neglect investigation?  Yes  No

If Yes, what were the results of the investigation?

10. Have there ever been any alleged or actual incidents regarding abuse or molestation?  Yes  No

Please describe:        
11. For residential risks, what steps are taken to ensure that client-to-client contact is avoided, i.e.,

separating male from female sleeping quarters:

12. Are children of different age groups housed together?  Yes  No

If Yes, please describe:

13. Are children left alone without any adult supervision?  Yes  No

14. List situations where an employee or volunteer has direct contact with clients in an unsupervised

situation without oversight of another staff member: (you may list on a separate sheet should you

require additional space for this answer)        
15. Is any counseling conducted off premises, i.e. clients’ or counselors’ homes?  Yes  No

If yes, by whom and what type of clients?

16. Is any counseling provided after normal business hours?  Yes  No

If Yes, describe:

17. If transportation is provided, is there more than one adult present at all times?  Yes  No

18. What is your procedure on how allegations of abuse are handled?

19. What is your written documentation procedure on how allegations of abuse are handled?

20. Are accused employees removed from client care responsibilities pending outcome of investigation?

Yes  No If No, please describe:

21. What procedures have been instituted to prevent reoccurrences of previous events?

*Section 4)* **Foster Care / Adoption**  *Does not apply*

1. Which Foster Care Services do you provide? (Check all that apply)

Licensing of the foster family  Placement decisions

Foster Family recruitment, training, and supervision  Case management

Working with the family of origin  Permanency planning

Removal of the child (adolescent and youth)  Certification of foster family

from the family or situation

2. Number of foster placements: Last year:       This year:

3. Number of foster families currently certified:

4. Staff count: Case Workers:       Supervisory:       Other:

5. Are there written procedures to review potential foster/adoptive families?  Yes  No

6. Are there criminal background checks for member of foster families?  Yes  No

7. Total number of hours/days of training for foster families:       Hours:       Days:

8. Are there follow-up visits after placement?  Yes  No If Yes, how often during

the year?

9. Are there adoption services?  Yes  No If Yes, total number of expected adoptions

during the year?

10. Any international adoptions?  Yes  No If Yes, total number of expected adoptions

during the year?

11. Are there criminal background checks for member of foster families?  Yes  No

12. What percentage of insured’s operation involves Foster Care?       Adoption?

13. Does the agency have an adequate number of staff for the foster/adoptive families and

children served?  Yes  No

14. Is the staff assigned adequately trained?  Yes  No

15. Does the agency operate in accordance with applicable laws/regulations?  Yes  No

*Section 5)* **Day Care Center / Nursery School Information**  *Does not apply*

Location Number(s):

1. Description of premises:

Private Home  Commercial Building  School

2. Interest: Owner  Tenant

3. Describe affiliation (church, school, other):

4. Part occupied by applicant (i.e., basement, 1st floor, 2nd floor):

5. Area occupied (sq. ft. dimensions):

6. Construction of building:  Frame  Brick  Non-Combustible  Fire Resistive

7. Number of floors:      Age of building:      Type of heating:

8. Does applicant have a play area:  Yes  No If Yes, describe equipment and list security measures

(e.g. locked gates etc)

9. Any “Yes” answers to the following must be described in remarks below (attach separate sheet if necessary):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Pools on the premises (must be fenced) | Yes | No | Animals, pets | Yes | No |
| Physically/Mentally handicapped or developmentally disabled children | Yes | No | Gymnastic equipment | Yes | No |
| Nurses, Therapists, Counselors | Yes | No | Unique/unusual teaching techniques | Yes | No |
| Field trips | Yes | No |  | | |

Remarks:

10. Is applicant licensed or certified as a Day Care Center/Nursery School?  Yes  No

If Yes, please attach a copy of the license.

If No, explain:

11. Has applicant ever been cited by authorities for day care violations with or without suspension or revocation of

certification or license?  Yes  No If Yes, explain in detain on separate sheet.

12. Does applicant require a release of liability from all children?  Yes  No

If no, will you institute such a program?  Yes  No

13. Applicant is licensed to care for children ages     to    . (If no license required, state maximum numbers)

Number children:

Under age 2:       From 3 to 5:       From 6 to 10:       Over age 10:

14. Applicant's ratio of supervisors to children is       to

15. Applicant operates     days per week from      to     . Average daily attendance of       children.

*Section 6)*  **Residential Care / Inpatient Care Facility**  *Does not apply*

1. Please list location numbers with residential care/inpatient facilities:

2. Full description of services rendered (Attach all brochures and promotional material):

3. Is the facility run by an outside management company?  Yes  No

If Yes, describe the relationship:        
4. How long under present management?

5. Date established:

6. Indicate estimated: Receipts $      *or* Operating Budget $      Payroll $

7. Is the applicant engaged in, owned by, owned by, associated with, or involved in any other enterprise?

Yes  No If Yes, describe:

8. Are you currently licensed for operation by the proper regulatory authorities?  Yes  No

(Attach a copy of the license.)  
 Is the license conditional?  Yes  No  
 If Yes, explain:

Has the license ever been revoked?  Yes  No

If Yes, explain:

M - Male

Total # Age of F – Female Length Client-staff

9. **Type of facility**: of beds residents or both of stay ratio

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcohol or Drug - Rehab |  |  |  |  |  |
| Alcohol or Drug - Treatment |  |  |  |  |  |
| Alcohol or Drug - Detoxification |  |  |  |  |  |
| Psychiatric Care |  |  |  |  |  |
| Shelter for runaways,abused spouses,foster children |  |  |  |  |  |
| Homeless Shelter Facility |  |  |  |  |  |
| School: (state type of school): |  |  |  |  |  |
| Group home - Mental/ Physical Rehab |  |  |  |  |  |
| Group home - Developmentally Disabled |  |  |  |  |  |
| Group home - Troubled Youth |  |  |  |  |  |
| Transitional Housing - Low-income |  |  |  |  |  |
| Aged - Independent living |  |  |  |  |  |
| Aged - including intermediate care |  |  |  |  |  |
| Aged - including skilled care |  |  |  |  |  |
| Hospice |  |  |  |  |  |
| Nursing home for senile or aged |  |  |  |  |  |
| Other (specify): |  |  |  |  |  |

Total number of bed for all facilities:

How many beds are currently occupied:

Is the facility (check one):  Co-ed or  Single Sex If Co-ed, how are patients segregated and

Monitored?

Are clients of different age groups segregated?  Yes  No Please describe:

Number of bedridden clients:

10. **Type of Client at all facilities above**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client** | **Ambulatory** | **Non-Ambulatory** | **Total Client** |
| Substance abuse patients- Rehab |  |  |  |
| Substance abuse patients- Treatment |  |  |  |
| Substance abuse patients- Detoxification |  |  |  |
| Somewhat mentally impaired (i.e. Senile) |  |  |  |
| Seriously mentally impaired (i.e. Alzheimer’s) |  |  |  |
| Aged but mentally and physically fully functional |  |  |  |
| Mentally/Physically disabled requiring intermediate care |  |  |  |
| Mentally/Physically disabled requiring skilled care |  |  |  |
| Other (Specify): |  |  |  |

11. What floors are the non-ambulatory patients on?       How many patients are on each floor?

12. Are restraints used?  Yes  No If yes, attach copies of restraining procedures that are in force.

13. Other operations:

|  |  |
| --- | --- |
| Counseling # of visits: |  |
| Home care # of visits: |  |
| Day time care # of clients: |  |
| Other (specify): |  |

14. If counseling is provided, describe (e.g., group therapy, individual counseling):

15. List other types of services provided (e.g., beautician services, podiatry, dentistry):

Provided for:       By staff:       By Contractors:

16. Ages of patients:

Under 18  18 – 35 yrs old  36 – 50 yrs old  51 – 65 yrs old  Over 65   
 Client to Staff Ratio:

17. Precautions taken to keep track of patients:

Sign out procedures?  Yes  No

Are there alarms on doors to prevent clients from wandering from the residence?  Yes  No  
 Other:

Are routine bed checks performed?  Yes  No How often?

Are they logged?  Yes  No   
18. Do any patients work full or part time jobs?  Yes  No

If Yes, what percentage of patients work:     % What type of work:        
19. Are any medications administered?  Yes  No

If Yes, list any medication administered and in what form given (e.g., Methadone, given in

pill form):

20. Is the insured a:  Building Owner  Tenant  General Lessee

Name any other tenants on the premises:

21. Explain average length of stay and type of treatment, i.e., alcohol, drug, psychiatric:

22. Is a Registered Nurse or M.D. on duty at all times?  Yes  No If No, explain availability:

23. Do staff members carry their own professional liability insurance?  Yes  No Explain in Detail:

24. Is any facility used for detoxification (withdrawal) of drug addicts and/or alcoholics?  Yes  No

If Yes, Explain:

*Section 7)* **Outpatient Facilities**  *Does not apply*

Location Number (s):

1. Outpatient Facilities/Treatment

a. Estimated number of client contacts\*\* per year (excluding Methadone):       Annual Visits:

b. Methadone maintenance:  Yes  No If Yes, estimated doses administered per year:

c. Counseling:  Yes  No

2. Does insured operate a clinic?  Yes  No If Yes, annual number of visits:

3. Does the insured operate a crisis hotline?  Yes  No If Yes, annual # of calls received:

4. Do you provide any services/programs for ex-offenders?  Yes  No If Yes, please describe type of

offenses:

5. Do you operate an adult day care facility and/or senior day care center?  Yes  No

If Yes, please answer the following:

1. Type of activities/services offered:
2. Total number of clients daily:       Annually:
3. Staff to client ratio:

6. Do you provide a meal delivery service?  Yes  No If Yes, annual number of meals served:

7. Do you offer training/vocational programs?  Yes  No If Yes, annual number of clients:

Types of programs offered:

8. Do you offer information or referral services to clients?  Yes  No If Yes, annual number of clients:

Types of referrals offered:

\*\*CLIENT CONTACTS: For the purpose of computing the premium charge, we count the following to

be a client contact, regardless of the discipline of the counselor:

1) Individual Counseling: Face-to-Face visit, including Outreach  
 2) Group Therapy: Each member of a group, each session   
 3) Day Care/Camps: Each client/day counts

*Section 8)* **Sheltered Workshop**  *Does not apply*

Location Number (s):

1. Estimated number of client days per year:

2. Maximum number of clients any one day:

3. Brief description of activities and nature of products:

4. Estimated annual receipts:

5. Do clients work with power equipment?  Yes  No

If Yes, please describe:

6. Is coverage for Products Liability desired?  Yes  No

7. How is the product sold?  Wholesale  Retail  Jobber  Direct

8. Are hold harmless agreements given to others in connection with products manufactured by

applicants?  Yes  No

9. Contractual Liability: Attach copy of all contracts to be covered other than the following' lease of

premises, easement agreements, side tract agreements, agreements required by municipal ordinance,

elevator maintenance agreement.

10. Any of the following performed:

|  |  |  |
| --- | --- | --- |
| Spray painting: | Yes | No |
| Discharge of fumes: | Yes | No |
| Discharge of acids or wastes: | Yes | No |
| Use of radioactive materials: | Yes | No |

Describe any hazard, on or away from the premises, not normally existing with this class of business:

*Section 9)* **Recreational Facilities / Camps**  *Does not apply*

Location(s):

Limits of Liability Requested:

***PLEASE ANSWER ALL QUESTIONS. IF THEY DO NOT APPLY, INDICATE “NOT APPLICABLE”***

**I) Applicant Premise Information**

1. Name of Facility/Camp (if different than Applicant)
2. Dates of Camp (if applicable)
3. Is the camp accredited by A.C.A?  Yes  No

4a. Is the camp a member of another camping association?  Yes  No

4b. If yes, which one(s)?

5. Is the facility  Co-ed  Boys  Girls

6. Is the facility  Day  Overnight  Travel

7. Years in Business:       Under Present Management:

8. Please indicate which of following activities campers are involved in:

|  |  |  |  |
| --- | --- | --- | --- |
| Horseback riding | Wilderness adventure | Football | Climbing wall |
| Archery ranges | Hiking | Volleyball | Basketball |
| Canoeing, boating | Swimming | Boxing/Wrestling | Baseball/Softball |
| Water sports (waterskiing, etc.) | Waterslide | Karate/Martial Arts | Soccer |
| Snow Sports (cross country skiing, snow-shoeing, etc.) | | Ropes course | Other |

9. Please provide details (including safety controls) for all activities the clients will be involved in during the duration

of their stay:

**II) Premium Basis (If Applicable)**

10. Estimated number of campers per day/week:       Annual:       Age range of campers:

11. Estimated number of days per week?      Weeks per year?

**III) Underwriting Criteria**

12. Total number of staff       Client to staff ratio?

13. Does the applicant have an accident & health policy?  Yes  No

If yes, who is the carrier, and what is the limit of liability?

14. Does the applicant require clients to sign waivers?  Yes  No

15. Any hold harmless agreements?  Yes  No

If yes, with whom and what is the nature of the agreement?

16. If *overnight camp*, please answer the following:

1. What type of cooking takes place (deep-fryers, etc.)?

1. What kind of fire suppression system is in the kitchen area?

1. Are the cabins/sleeping areas equipped with hard wired smoke detectors?  Yes  No
2. Is there a no smoking policy in place for campers/staff (or a designated smoking area)?  Yes  No

Are camp fires allowed, and if so, where & how are flammables stored?

1. Is there an evacuation plan in place (in case of natural disaster or forest fire)?  Yes  No

17. Does the facility specialize in camping experiences for physically or developmentally disabled individuals?  Yes  No

If yes, please provide a complete narrative of such program(s) below or on a separate sheet, if necessary:

*Section 10)* **In-Home Support Services**  *Does not apply*

1. **Services Provided:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Nursing Care | Speech therapy | | | Bathing |
| Changing catheters | Social work | | | Laundry |
| Infusion therapy | Nutrition counseling | | | Meal preparation |
| Medical management | Repositioning | | | Housework |
| Blood testing | Restroom aid | | | Dressing |
| Other: | | Other: | Other: | |

2. How long has the program been in place?

3. How many employees provide in-home services?       Volunteers?

4. How many “Nursing” visits (column #1) do you provide annually?

5. How many other visits (columns #2 & #3) do you provide annually?

6. Do you have procedures in place regarding client security?

7. How do you monitor in-home service providers?

*Section 11)* **Employee Dishonesty Supplement** *Does not apply*

**GENERAL**

1. Total number of employees:       Total number of volunteers:

2. Number of employees who handle money, securities or other property:

3. Is your operation a Non-Profit Organization?  Yes  No

4. What is your annual budget?

5. Do you expect the number of employees/volunteers to grow substantially this year?  Yes  No

6. Name of current insurance carrier and employee dishonesty limits:

7. Why are you requesting this limit?

**LOSSES**

8. List any losses during the past 5 years: (Include description and amount of loss along with

remedial action taken to prevent further losses):

9. At the present time, do you suspect any dishonest activity in your operation?  Yes  No

10. Has your organization ever contacted authorities to investigate suspected dishonest acts by one of your employees?

Yes  No

If Yes, please explain circumstance:

**PROTECTIVE CONTROLS**

11. Is an annual audit performed by an outside C.P.A.?  Yes  No

12. Will there be an audit by an officer or employee who is a C.P.A.?  Yes  No

How often?       By whom?

13. Are audit reports given directly to the Board of Directors?  Yes  No

14. At what level of check amounts are countersignature required on all checks?

$1,000 or less  $1,001 - $2,500  $2,501 - $5,000  Over $5,000  All Levels

15. Does someone not making deposits or withdrawals reconcile the monthly bank statement?  Yes  No

16. Is inventory (example: computers and office equipment) monitored and tracked?  Yes  No

17. Is verification or review made on accounts receivables ledger by a staff member other

than the person(s) normally working with such records?  Yes  No

How often?       By whom (position):

18. Do branch locations of your operation bank locally?  Yes  No

If Yes, are duplicate copies of monthly bank statements & deposit slips sent direct to

the main office by the bank?  Yes  No If Yes, are duplicate copies of monthly

bank statements & deposit slips sent direct to the main office by the bank?  Yes  No

**COMPUTER CONTROLS**

19. Do you use a computer for any accounting, payroll, payment, or banking function?  Yes  No

If Yes, is output reconciled or audited by persons who do not prepare the input or process it?  Yes  No

**PURCHASING OR RELATED FUNCTIONS**

20. Are any employees permitted to have a financial interest in firms that supply goods or

services to your organization?  Yes  No

21. Is there a policy prohibiting staff from accepting gifts or favors from suppliers or clients?  Yes  No

22. Are purchase orders used?  Yes  No If Yes, are they pre-numbered and are copies

made for accounting department staff?  Yes  No

23. Does any one person have sole authority to handle the order placement & disbursement?  Yes  No

24. Are suppliers’ invoices matched with related purchase orders & attached to the checks for

review at the time the checks are signed?  Yes  No

25. Are invoices cancelled or stamped “paid” after payment is made to avoid reuse?  Yes  No

26. Do you have a positive system to detect payment to fictitious suppliers?  Yes  No

**AUTHORITY OF EMPLOYEES**

27. List the names, positions and tenure of the employees authorized to do any of the following activities:

Sign Checks:

Handles Bank Deposits:

Approve Payroll:

*Section 12)* **Auto Supplement**   *Does not apply*

1. Are patients/clients transported in vehicles?  Yes  No

2. Describe the type of occupants:

|  |
| --- |
| Physically Handicapped  Elderly  Mentally Handicapped  Non-Ambulatory  Children  Other (describe): |

3. List Safety Measures on board vehicles:

|  |  |  |
| --- | --- | --- |
| * Is seat belt use mandatory? | Yes | No |
| * Is there a matron on board? | Yes | No |
| * Are there wheelchair lifts? | Yes | No |
| * Are there wheelchair mounts within vehicle? | Yes | No |
| * Any medical support equipment on board? | Yes | No |
| * Any first aid equipment on board? | Yes | No |

4. How often are vehicles used?       What are vehicles used for:

5. What is the normal radius of operation?

6. Is there any interstate travel?  Yes  No If Yes, please describe:

7. Are professional drivers used?  Yes  No

8. Do you order motor vehicle reports on all drivers?  Yes  No

9. Do volunteers operate vehicles?  Yes  No

10. How are drivers equipped to handle the specific type of occupant?

11. Are all drivers covered by Workers Compensation?  Yes  No

12. Any drivers under 25 years of age?  Yes  No Over 60 years of age?  Yes  No

13. Is a driver log maintained?  Yes  No

14. Are any vehicles driven by handicapped personnel?  Yes  No

If Yes, how are vehicles equipped?

15. Is there a formal maintenance program?  Yes  No

16. Who services vehicles?

17. Where are vehicles stored overnight?

18. Are there any owned or leased vehicles covered under a different policy?  Yes  No

If yes, explain:

19. Are employees permitted to take vehicles home?  Yes  No

If Yes, how often?

20. Are employees vehicles used?  Yes  No If Yes, how often?

21. Are volunteer vehicles used?  Yes  No If Yes, how often?

22. Does the insured obtain copies of auto policies from volunteers or employees?  Yes No

23. Any vehicles rented or leased from others?  Yes  No

If Yes, how often?       With or without driver?

Are certificates of insurance obtained from the lessor?  Yes  No

What limits are required?

**Hired / Non-owned Auto Information**  *Does not apply*

1. Any Owned Autos?  Yes  No

2. Number of Employees:       Number of Volunteers:

3. Do the employees or volunteers use their own vehicles on behalf of the insured?

Yes  No If Yes, enter the approximate number of employees/volunteers that use their own vehicle for

company business:

Never:       Occasionally:       Frequently:

4. How many drivers run errands using their own vehicles for company business?

5. How many drivers transport clients in their own vehicles for company business?

6. Do you obtain copies of insurance policies for volunteers and employees who use their

own vehicles?  Yes  No

7. Are these records updated at least yearly?  Yes  No

8. Do you require insurance limits of at least 100/300/100?  Yes  No

If No, what limits do you require?

9. Are MVR’s checked on volunteers/employees?  Yes  No

10. Do you have a driver safety program?  Yes  No

11. Are seat belts required to be worn by all occupants?  Yes  No

12. In order to obtain non-owned coverage, it is required for your own protection that all employees/volunteers who

use their own vehicles regularly maintain personal auto limits of 100/300/100 with a copy of current insurance

limits on file with the non-profit. Are you willing to follow this procedure to protect

the non-profit?  Yes  No

**Part II**  **Staff Profile**  - **PROFESSIONAL LIABILITY**

**CLAIMS MADE  OCCURRENCE**

If this is a claims-made policy, please indicate retro date:       (Complete Attachment B)

**Current Limits:** **Occurrence/Aggregate**

1. Describe professional services provided:

2. Is the agency licensed by the state or by another regulatory agency?  Yes  No

If Yes, please describe:

3. Total client contacts per year:

4. Does the agency have any residential inpatient facilities?  Yes  No

(If you answered “Yes” to question #4, please complete residential section - Part I, Section 6)

5. Please provide the number of each type of caregiver below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Independent Contractor** | **Employed** | | **Volunteer** | | **TOTAL** |
|  | **Full Time** | **Part Time** | **Full Time** | **Part Time** |
| Homemaker, Home Health, Nurse’s Aide, Sitter, Companion, Bereaval Therapist, Occupational Therapist, Paraprofessional Social Worker, Teacher |  |  |  |  |  |
| LPN, Social Worker (BA), Dietician, Nutritionist, Dental Hygienist, Pharmacy Assistant, Lab Technician, Medical Tech, Radiology Tech, Certified Medical Asst. |  |  |  |  |  |
| Counselor, RN, Social Worker (MA, MSW), Speech Pathologist, Dialysis Tech, Enterstomal Therapist , Clergy |  |  |  |  |  |
| Medical Director , Project Director |  |  |  |  |  |
| Pharmacist |  |  |  |  |  |
| Physical Therapist, Respiratory Therapist, Phlebotomist, Nuclear Medicine Tech, Radiation Therapist |  |  |  |  |  |
| Psychologist |  |  |  |  |  |
| Nurse Practitioner, Physician Assistant, Paramedic, EMT |  |  |  |  |  |
| Psychiatrist, Dentist (\*\*Must complete Attachment A ) |  |  |  |  |  |
| Medical Doctor / D.O. / Podiatrist Acupuncturist (\*\* Must complete Attachment A ) |  |  |  |  |  |
| Other (Client Contact Only)  Describe: |  |  |  |  |  |

Volunteer

**Please include a STAFF PROFILE with your submission.**

**\*\*Note: For professional coverage on these highlighted staff type above, each and every**

**Psychiatrist, Medical Doctor, D.O., and Podiatrist must complete “Attachment A”.**

6. Do you have any contractual agreements to provide services?  Yes  No

If Yes, please describe:

Applicant Signature/Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Umbrella Liability Section

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

|  |  |
| --- | --- |
| Name of Insured: |  |

**Limits of Liability**

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Pre Occurrence | 200,000 | Yes  No |
| Aggregate Excess of Underlying Coverages & Limits Retentions | 200,000 | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Underlying Policies** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| General Liability |  | Yes  No |
| Automobile |  | Yes  No |
| Garage automobile |  | Yes  No |
| Non-Owned Aircraft |  | Yes  No |
| **Insurers Wording Including** | | |
| Pay on Behalf Insuring Agreement |  | Yes  No |
| Follow Form |  | Yes  No |
| Broad Form PD |  | Yes  No |
| Blanket Contractual |  | Yes  No |
| Employers’ Liability |  | Yes  No |
| Employee Benefits |  | Yes  No |
| Incidental Medical Malpractice |  | Yes  No |
| Fire Fighting Expense |  | Yes  No |
| Personal Injury |  | Yes  No |
| Real Property CCC |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Named Insured |  | Yes  No |
| No Exclusion for Punitive Damages |  | Yes  No |
| Excess Automobile |  | Yes  No |
| Pollution (IBC 2313) |  | Yes  No |
| Worldwide Territory |  | Yes  No |
| Cancellation – 90 Days Notice |  | Yes  No |

Crime Section

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

|  |  |
| --- | --- |
| Name of Insured: |  |

|  |  |  |
| --- | --- | --- |
| **Limits of Liability** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Employee Theft |  | Yes  No |
| Loss Inside the Premises |  | Yes  No |
| Loss Outside the Premises |  | Yes  No |
| Money Orders and Counterfeit Currency |  | Yes  No |
| Depositors’ Forgery |  | Yes  No |
| Computer Fraud and Funds Transfer Fraud |  | Yes  No |
| Credit Card Forgery |  | Yes  No |
| Client Coverage |  | Yes  No |
| Employee Benefit Coverage |  | Yes  No |

**Retentions**

|  |  |  |
| --- | --- | --- |
| Options : |  | \*Nil retention for Employee Benefit Plans |

**Coverages**

|  |  |  |
| --- | --- | --- |
| **Limits of Liability** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| 120 days Notice post Discovery of Loss |  | Yes  No |
| Proof of Loss required within 6 months of Discovery |  | Yes  No |
| Funds Transfer Fraud for Money, Securities, Property and Merchandise |  | Yes  No |
| 12 months Discovery Period |  | Yes  No |
| 120 days Notice of Cancellation |  | Yes  No |
| 60 days Notice of Non-renewal |  | Yes  No |
| Audit Expenses for all Insuring Clauses – $250,000 |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Reproduction Costs |  | Yes  No |
| Definition of Employee to include Non-compensated Directors, Officers and Trustees |  | Yes  No |
| Temporary Employees excess of Agency coverage |  | Yes  No |
| Part-time, Contract or Seasonal Employees |  | Yes  No |
| Students |  | Yes  No |
| Retired Employees acting as Consultants |  | Yes  No |
| Automatic Acquisition coverage < 20% of Assets, 90 day Notice provision |  | Yes  No |
| Prior Fraud Tolerance Level of $25,000 |  | Yes  No |
| Unidentifiable Employee clause |  | Yes  No |
| Ex-employees covered for 90 days post termination |  | Yes  No |
| Employee Cross-over Rider |  | Yes  No |
| Employee Benefit Plans included as Insureds |  | Yes  No |
| Worldwide Territory |  | Yes  No |
| Designated Reps under “Notice,” Prior Dishonesty,” “Discovery,” and “Cancellation” clauses |  | Yes  No |
| Toll Fraud coverage |  | Yes  No |
| Worldwide Currencies under Money Orders and Counterfeit Currency |  | Yes  No |
| Include “Telefacsimile” under Funds Transfer Fraud |  | Yes  No |
| Professional Liability Loss History |  | Yes  No |

**Crime Losses Summary by Policy Year**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Summary by Policy Year: From ( ) to ( )** | | | | |
| **Policy Year** | **Net Amount Paid (# Claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
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Automobile Fleet Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. | | | |  | | |
|  | | |  | | | | |
| Named Insured: | | |  | | | | |
|  | | |  | | | | |
| **Vehicles**  All vehicles owned by, licensed and/or leased to the named insured. | | | |
| **Coverage** | | | | **Limit of Coverage** | | **Coverage Provided** | | |
| Third Party Liability | | | |  | | Yes  No | | |
| Accident Benefits (per provincial requirements) | | | |  | | Yes  No | | |
| Loss or Damage to Insured Automobile | | | |  | | Yes  No | | |
| All Perils – Deductible | | | |  | | Yes  No | | |
| Comprehensive – deductable | | | |  | | Yes  No | | |
| Specified Perils – deductable | | | |  | | Yes  No | | |

|  |  |  |
| --- | --- | --- |
| **Endorsements** | | |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| OPCF 2 – Permission to Drive Other Automobiles |  | Yes  No |
| OPCF 4A – Permission to Carry Explosives |  | Yes  No |
| OPCF 4B – Permission to Carry Radioactive Material |  | Yes  No |
| OPCF 5 – Permission to Rent or Lease Automobiles |  | Yes  No |
| OPCF 6A – Permission to Carry Paying Passengers |  | Yes  No |
| OPCF 20 – Coverage for Transportation Replacement |  | Yes  No |
| OPCF 21B – Blanket Coverage |  | Yes  No |
| OPCF 27 – Physical Damage to Non-Owned Automobiles |  | Yes  No |
| OPCF 27B – Business Operations: Physical Damage to Non-Owned Autos |  | Yes  No |
| OPCF 43/43A – Removing Deprecation Deduction (      Months) |  | Yes  No |
| OPCF 44R – Family Protection Endorsement |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Others** | | |
| Blanket Lessors |  | Yes  No |
| Cross liability |  | Yes  No |
| Cancellation – 90 Days Notice |  | Yes  No |
| Contingent Profit Agreement |  | Yes  No |
| **Endorsements** | | |
| QEF 2 – Drive Other Automobiles |  | Yes  No |
| QEF 4A – Transportation of Explosives |  | Yes  No |
| QEF 4B – Transportation of Radioactive Materials |  | Yes  No |
| QEF 5A – Lease or Leasing |  | Yes  No |
| QEF 20 – Loss of Use Extension |  | Yes  No |
| QEF 21B – Blanket Fleet Coverage |  | Yes  No |
| QEF 27 – Civil Liability for Damage to Non Owned Automobiles |  | Yes  No |
| QEF 34 – Accident Benefits |  | Yes  No |
| QEF 43 – Change to Loss Payment |  | Yes  No |
| **Endorsements** | | |
| SEF 2 – Drive Other Automobiles |  | Yes  No |
| SEF 4A – Permission to carry explosives |  | Yes  No |
| SEF 4B – Permission to carry Radioactive material |  | Yes  No |
| SEF 5 – Permission to Rent or Lease |  | Yes  No |
| SEF 6A – Permission Carry Passengers for Compensation |  | Yes  No |
| SEF 20 – Loss of Use Extension |  | Yes  No |
| SEF 21B – Blanket Fleet Coverage |  | Yes  No |
| SEF 21D – Express Coverage Blanket Fleet (mb, sk, bc) |  | Yes  No |
| SEF 27 – Legal Liability for Damage to Non Owned Automobiles |  | Yes  No |
| SEF 43R – Limited Waiver of Depreciation -       months |  | Yes  No |
| SEF 43L – Limited Waiver of Depreciation -       months |  | Yes  No |
| SEF 44 – Family Protection Endorsement |  | Yes  No |
| BCSEF 41 – Limitation of Third Party Liability to Excess Insurance (BC) |  | Yes  No |
| EEF 1 – Saskatchewan Excess |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Others** | | |
| Manitoba Excess |  | Yes  No |
| Cancellation – 90 days notice |  | Yes  No |
| Blanket Lessors |  | Yes  No |
| NFLD – Basic Accident Benefits |  | Yes  No |
| Cross Liability |  | Yes  No |
| Contingent Profit Agreement |  | Yes  No |

**Automobile Business Purpose**

|  |  |  |
| --- | --- | --- |
| **Fleet Information** | **Comment** | |
| 1. Present company and policy # |  | |
| 1. How long present company had the risk |  | |
| 1. Applicant’s business |  | |
| 1. Number of vehicles in each of preceding 3 years |  | |
| 1. Use of vehicles and types of goods hauled |  | |
| 1. Special Endorsements Required? | Yes  No | Explain: |
| 1. Filings Required? | Yes  No | Explain: |
| 1. Radius of Operations |  | |
| 1. U.S. Exposures? | Yes  No | Explain: |
| 1. Describe screen and testing procedures of new and existing drivers (especially commercial vehicles) |  | |
| 1. Are MVR’s ordered for all new drivers? | Yes  No | Explain: |
| 1. Are MVR’s Ordered on other than new drivers? | Yes  No | Explain: |
| 1. Describe loss prevention and/or fleet safety programs in place (include vehicle maintenance) |  | |

**Schedule of Vehicles**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Prov** | **Year** | **Make/Model** | **Serial Number** | **Use/Radius of Operations (KMs)** | **Cost New Incl. Equipment** |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |
|  |  |  |  |  | $ |

**Driver Information**

|  |  |  |
| --- | --- | --- |
| **Name of Driver** | **Licence Number** | **Cell Phone** |
|  |  |  |
|  |  |  |
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Automobile Loss History

**Automobile Loss History Detailed : From       To**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Cause / Description** | **Net Amt. Paid** | **Ded.**  **Amount** | **Adjust Expenses** | **Outstanding** | **Gross Total** |
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Garage Automobile Section

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

|  |  |
| --- | --- |
| Insured: |  |

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| OAP 4, QPF 4, SF 4 – Standard Garage Automobile |  | Yes  No |
| Third Party Liability |  | Yes  No |
| Accident Benefits – Options as per Provincial Requirements |  | Yes  No |
| Uninsured Automobile |  | Yes  No |
| Legal Liability for Damage to Customers’ Vehicles |  | Yes  No |
| Collision or Upset |  | Yes  No |
| Any one vehicle |  | Yes  No |
| Deductable |  | Yes  No |
| Specified Perils |  | Yes  No |
| Each Location |  | Yes  No |
| Deductable |  | Yes  No |
| **Endorsements** | | |
| SEF 71, OEF 71, QEF 71 – Excluding Owned Automobiles |  | Yes  No |
| SEF 77, OEF 77 – Liability for Comprehensive Damage to Customers’ Automobiles (including open lot theft) |  | Yes  No |
| Cross Liability |  | Yes  No |
| Cancellation – 90 Days Notice |  | Yes  No |

**Garage Loss History Detailed : From       To**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Cause / Description** | **Net Amt. Paid** | **Ded.**  **Amount** | **Adjust Expenses** | **Outstanding** | **Gross Total** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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Criminal Legal Defence

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

Coverage for allegations, claims or suits alleging criminal conduct for employees, board member, foster parents, teachers, volunteers, counselors with limits up to $100,000. Each insured person has access to lawyers who have expertise in the matters covered by the policy and the legal fees and disbursements are paid directly to the lawyer by the insurer.

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Limit of Coverage** | **Coverage Provided** |
| Legal Expense Insurance Coverage | 200,000 | Yes  No |
| Employment Disputes | 200,000 | Yes  No |
| Legal Defence | 200,000 | Yes  No |
| Bodily Injury | 200,000 | Yes  No |
| Statutory Licence Protection | 200,000 | Yes  No |
| tax Protection | 250,000 | Yes  No |
| Contract Disputes & Debt Recovery | 200,000 | Yes  No |
| Telephone Legal Advice Service | 200,000 | Yes  No |
| Deductable | | |
| Wrongful Act | 2,500 | Yes  No |

Accidental Death & Dismemberment

|  |  |
| --- | --- |
| Quotation  New Business  Renewed  Replacing Policy No. |  |

To provide benefits to Insured Persons in the event of an accident that results in the bodily injury, dismemberment or death.

|  |  |
| --- | --- |
| Insured |  |

|  |  |  |
| --- | --- | --- |
| **Limit of Coverage Options** | | **Coverage provided** |
| Class 1 (a) | Chiefs, Council Members, Board Members, Trustees, Directors | 200,000 Principal Sum |
| Class 1 (b) | Police and Security Guards | 200,000 Principal Sum |
| Class 1 (c) | Firefighters | 200,000 Principal Sum |
| Class 1 (d) | Teachers | 200,000 Principal Sum |
| Class 2 (a) | Volunteers | 50,000 Principal Sum |
| Class 2 (b) | Part-time employees and Full-time Employees NOT included in Class 1 | 50,000 Principal Sum |
| Class 3 | Spouse or Dependent Child of all Class 1 insured persons | 10,000 Principal Sum |
| Class 4 | Children attending Day-Care Centres or Educational Centres over six (6) months and under eighteen (18) years of age | 20,000 Principal Sum |

Premium is based on all insured under the age of 70 years old.

Claims History

**Summary by Policy Year: From       To**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Policy Year** | **Net Amount Paid (# Claims)** | **Adj. Expenses** | **Outstanding** | **Total** |
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Ventures Schedule of Values

|  |  |  |  |
| --- | --- | --- | --- |
| Occupancy (Usage) |  | Building Value |  |
| Other Contents |  | Equipment |  |
| Stock |  | Business Interest |  |
| Rents Value |  | Year Built |  |
| Area (Square Feet) |  | Number of Stories |  |
| Floor |  | Roof |  |
| Roof Covering |  | Nearest Fire Dept. |  |
| Fire Hydrants (Distance) |  | Fire Alarm Type |  |
| Extinguishing System |  | Extinguishing Agent |  |
| Electrical |  | Plumbing |  |
| Heating |  | Fuel |  |

Ventures Auto Schedule

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Model** | **VIN** | **Value** | **Use** | **Class** | **RIN#** | **Registered To** |
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Declaration

The Proposer declares and warrants that after full and reasonable enquiry and investigation and to the best of his/her knowledge and belief all statements and particulars contained in this Proposal Form and (if applicable) any addenda hereto are true and that no information whatsoever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal Form and that should the above particulars alter in any way confirms that he/she will advise the Underwriters as soon as is practicable.

The Proposer further declares and warrants that he/she has been duly authorized by the Directors and Officers and the Company to act as their agent in respect of all matters of any nature or kind relating to or affecting this Proposal Form and the Policy.

The Proposer understands that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal Form may result in the Underwriters refusing to provide indemnity or voiding the Policy in every respect.

The Proposer hereby agrees and accepts that this Proposal Form and (if applicable) addenda hereto shall be the basis of the contract of insurance if entered into.  
  
he Underwriters are hereby authorized, at their absolute discretion, to make any investigation and enquiry in connection with regard to this Proposal Form as they deem necessary.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |
|  |  |  |
| Name of Signatory |  | Position |
|  |  |  |
| Contact Person |  | Telephone # |

**Attached Documents**

* Exposure Data
* Schedule of Locations and Values
* Claims History
* Risk Control
* Policy Wording
* Claims Administration
* Other Supporting Documents