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Community Service Business Unit
Elder Care Supplemental Form

Please note: This supplemental form must be completed in addition to the General Application

General Information

Legal Name of Applicant		Key Broker Contact	
Mailing Address		Brokerage Name	
Postal Code		Brokerage Address	
Email		Postal Code	
Website		Phone and Email	

Does the owner, or staff member(s) reside in the facility? YES ☐ NO ☐

Is the Applicant municipally owned and operated? YES ☐ NO ☐

Is the Applicant licensed within the Province of operation? YES ☐ NO ☐

List all Associations the Applicant belongs to and criteria for membership.

Has membership or registration ever been suspended, withdrawn, amended, declined or had conditions attached? YES ☐ NO ☐
If yes, please explain.

Has the Applicant ever been declined, non-renewed or cancelled by any Insurer? YES ☐ NO ☐
If yes, please explain.

Number of Beds By Type

Extended Care _____
Nursing Care _____
Independent Living _____
Residential Care _____
Long Term Care _____

Are all professionals licensed/certified to practice in the province? YES ☐ NO ☐
If No, please explain.

How are qualifications of professional staff checked?

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Do all qualified medical staff, including any interns, residents and fellows have CMPA coverage? YES ☐ NO ☐

If Yes, do you obtain proof of CMPA coverage? YES ☐ NO ☐

If No, please describe alternative insurance arrangements and for whom those arrangements apply.

Do any professional staff have liability/professional insurance coverage elsewhere? YES ☐ NO ☐

Does the Applicant or any of its employees perform activities outside of Canada or for patients residing outside of Canada? Please provide details.

Does the applicant comply with all provincial guidelines with respect to: YES ☐ NO ☐

- Needle stick injuries
- Safe handling, collection & disposal of dressings, waste, blood/blood products and sharps
- Patient lifting/moving
- Infectious disease prevention & control

If no, please explain.

Are vulnerable sector police checks performed on all applicable employees and volunteers in accordance with the Criminal Records Act? YES ☐ NO ☐

If no, please explain.

Do any non-medical staff administer medication? YES ☐ NO ☐

If yes, please explain.

APPLICANT ACKNOWLEDGEMENT

The undersigned authorized officer of the organization declares that, to the best of his/her knowledge, the statements set forth herein are true. Signing of this application does not bind the Insurer to offer, nor the Applicant to accept Insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and this form will be attached to and become part of the policy.

The undersigned, on behalf of the insured organization, acknowledges that any personal information provided in connection with this application (including but not limited to the information contained in this form) has been collected in accordance with applicable privacy legislation and this information shall only be used or shared by the Company to assess, underwrite and price insurance products and related services, administer and service insurance policies, evaluate and investigate claims, detect and prevent fraud, analyze and audit business results and/or comply with regulatory or legal requirements.

Applicant Name _____ **Title/Position** _____

Applicant Signature _____ **Date** _____

Broker Name _____

Broker Signature _____

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