



Intact Insurance Company

Application for Home Nursing/ Home Care Services' Liability Insurance

All questions are to be answered as completely as possible. If a question is not applicable to your situation state N.A. If insufficient space, attach full details.

1. Name of Applicant:

Mailing Address:

(Number)

(Street)

(City)

(Prov.)

(Postal Code)

2. Applicant is an Individual Partnership Corporation Other (give details):

3. Name, Address and Business of all Subsidiary Companies:

4. How long has Applicant been in his/her current occupation or business?

5. Description of all services provided by the Applicant:

6. Do you provide any services to patients on your own premises? Yes No

If yes, provide full details:

7. Total Gross Revenue: Previous Year: Anticipated Next Year:

8. Employees (including workers hired under contract):

	Number	Hours Worked	Accreditation
Registered Nurses			
Registered Practical Nurses			
Homemakers			
Others (please describe)			

9. List any professional associations, organizations or societies of which Applicant, or his/her employees is a member:

10. Does the Applicant, or his/her employees, have Professional Liability Insurance through a Professional Association? Yes No

If yes, state:

Professional Association	Number	Limits		Primary or Excess
		Per Claim	Aggregate	

11. Are services provided supervised, or under the direction, of a medical doctor? Yes No

If yes, provide details about the reason for supervision:

12. How does the Applicant contact patients?
 a) Do you advertise? Yes No
 b) Are they referred by: Doctor Hospital Other (please describe):
13. Do you offer any services outside of Canada? Yes No
 If yes, please describe:
14. What classes of patients are treated? State approximate percentage for each:
 Medical: % Surgical: % Mental: %
 Drug Addicts: % Alcoholics: % Other: %
 If other, give details:
15. Are services paid for by: Government Patient
16. Has the Applicant entered into any written contracts for the provision of services to any Organization, Institution or Patient? Yes No
 If yes, explain fully and submit a copy of the contract:
17. What procedures do you follow to screen prospective employees?
 Check institutional references Police check
 Others, please describe:
18. a) Do you have a formal written policy for your employees relating to their relationships with their patients including physical, sexual and mental abuse? Yes No
 b) What are your procedures for handling allegations or complaints made about your employees?
19. Have any allegations of abuse been made against you, your employees, or any other person associated with your organization during the past ten years? Yes No

If yes, give full details including whether such allegations were made to any Governmental authority, including the police.

20. Give details of all liability insurance carried during the past three years:

Type of Policy		Policy Number	Insurer	Policy Limit	Policy Period
Claims Made	Occurrence				
*					
*					
*					
*					

****If the policy is subject to a Retroactive Date, give details:***



21. Give details of all liability insurance claims brought against the Applicant, or any of your employees during the past five years:

Date of Accident	Amount		Details
	Paid	Outstanding	

22. Do these paid or outstanding amounts reflect any deductible provision(s) contained in existing or previous insurance policies? Yes No

If yes, to what coverage(s) does/did the deductibles apply and what is/was the deductible amount?

23. Is the Applicant aware of any incidents, not yet reserved, that may result in claims against you? Yes No

If yes, give details:

24. Limits of Insurance required:

Commercial General Liability:

Each Occurrence \$

Products Completed Operations Aggregate Limit \$

Personal Injury Limit \$

Tenants Legal Liability Limit \$ Any one premises Broad Form

Medical Expense Limit \$ Any one person

Non-Owned Automobile \$ Inclusive limit for bodily injury and property damage combined.

Professional Liability:

Each Claim \$

Aggregate: \$

I/We declare that during the last five years no insurer has cancelled, declined or refused to issue me/us any form of liability insurance and that this application discloses the hazards known to exist at the date of this application.

I/We declare that the statements made herein are in every respect true and correct and hereby apply for a contract of insurance to be based upon the truth of the said statements.

Signed by: _____

Date: _____

Position: _____

Broker: _____

Signing of this form does not bind the Applicant to complete the insurance.