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Community Services Business Unit
Health And Wellness Operations Supplemental Form

For all Health and Wellness Operations

Risks such as: rehabilitation facilities, family practitioners, respite care facilities, medical diagnostic laboratories, in home nursing care, residential treatment centres, disability support services, youth or group homes and more.

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	

Operations and Licensing Information

Describe **all** operations of the Applicant including any Group Homes or Treatment Facilities

Number of Group Homes or Treatment Facilities ______

Number of Residents per Group Home or Treatment Facility ______

Ratio of caregivers to group home residents ______

If operations include residents, does owner reside in the Facility? YES ______ NO ______

For Non-Group Home or Treatment Facilities – Number of Residents ______

Maximum number of beds ______

Ratio of caregivers to patient/residents ______

What are the criteria for persons to be admitted to the facility? ______

What is the age range of the residents of the facility? ______

Number of Persons Accessing Service ______

Is there mixed gender in home? YES ______ NO ______

If yes, is there segregation?

For applicable operations, annual number of client visits/clinical encounters ______

If the Applicant offers respite care (temporary relief for a primary caregiver) do any of the staff stay over night with the clients? YES ______ NO ______

Is the respite care area separate from the facility? YES ______ NO ______

Is there 24-hour supervision? YES ______ NO ______

Is the Applicant licensed within the Province of Operation? (Please submit a copy of the Ministry License) YES ______ NO ______

If diagnostic laboratory, indicate the type of diagnostic tests run

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Employee Information

Category	# of Full-Time	# of Part-Time
Registered Nurses (RN) & Nurses		
Registered Nurse Practitioners (RPN)		
Restorative Nurse Assistants (RNA)		
Counsellors		
Physiotherapist		
Occupational Therapist		
Social Worker		
Personal Support Workers (PSW)		
Others (include Volunteers)	**# of Full-Time**	**# of Part-Time**

Are all professionals licensed/certified to practice in the province? YES ________ NO ________

Do all qualified medical staff, including any interns, residents and fellows have professional insurance coverage? YES ________ NO ________

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

Describe policies/procedures for administering medications (including whether all staff (including non-medical staff)) are allowed to do so

Activities and Trips

Attach complete details of all **activities** and **trips** off premises (including information on the frequency, duration, purpose and destination, number of residents attending, number of staff, number of volunteers, method of transportation and supervision involved).

If more than one activity or trip (off premises) we must have all the above information for each activity and/or trip

Activities and Trips Non-Owned Automobile Exposure

Do you hire private transportation (e.g., buses)? YES ________ NO ________

Do staff or volunteers transport residents (for any reason) in their own vehicles? YES ________ NO ________

If yes, do you confirm they always carry a valid driver's license and minimum insurance requirements? YES ________ NO ________

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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