

**COMPLEMENTARY APPLICATION FOR COMERCIAL GENERAL LIABILITY APPLICATION  
AND ERROR & OMISSION EXTENSION**

ALTERNATIVE RESOURCES

Please answer all questions. If some do not apply to your facility, enter n / a.

Name of applicant :	
Risk address :	
City :	
Province :	Postal Code :

Number of years as an owner or operator :					
Number of years of experience in this business if the owner or operator for less than two years:					
Current capacity :	Lease :	<input type="checkbox"/> Annual	Number of resident per categories:	Independent living :	
		<input type="checkbox"/> Monthly		Assisted living :	
		<input type="checkbox"/> Non		Dependant living :	
Type of clientele: <i>Alternative Resources</i>	<input type="checkbox"/> Women shelter <input type="checkbox"/> Youth	<input type="checkbox"/> Drug addiction <input type="checkbox"/> Alcohol addiction	<input type="checkbox"/> Aids <input type="checkbox"/> Handicapped	<input type="checkbox"/> Homelessness <input type="checkbox"/> Mental health	<input type="checkbox"/> Other :
Number of employees	By category CPR and First Aid: Assistance to residents Administration / Office: Other: describe:				
Describe auditing measures when hiring a new employee :					
Are a code of ethics and written policies in regard to physical and sexual abuse given to employees upon hiring? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<b>Care and drugs</b>	
Are drugs kept under lock and key?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you keep a registry of drugs? If not, describe the preventive measures currently in place::	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any non prescription medication administered or distributed? If yes, what kind of drugs: How often: Under what conditions are these drugs are distributed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are resident visited by a doctor? If yes, at what frequency?.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is nursing provided? If yes, indicate the frequency:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is it provided by a person other than a nurse? If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Number of residents receiving the following treatments:	Assistance for hygiene, food and clothing Health conditions monitoring Hygiene and food preparation monitoring Therapy Administration of prescription drugs
---------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**COMPLEMENTARY APPLICATION FOR COMERCIAL GENERAL LIABILITY APPLICATION  
AND ERROR & OMISSION EXTENSION**

Describe the activities offered on site:	Frequency per year
Describe Activities offered off site:	
Describe additional services provided by your institution:	
Swimming pool on site <input type="checkbox"/> Yes <input type="checkbox"/> No	SPA or therapeutic baths <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any financing activities organized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how often? Describe the type of activity:	

<b>Protection</b>			
Connected fire alarm? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency light in the corridors and stairwells <input type="checkbox"/> Yes <input type="checkbox"/> No		
Smoke detectors? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency exits clearly marked? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Portable fire extinguishers? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Over the past five (5) years, did an insurer refused to renew or cancelled a similar insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Over the last five (5) years, did the applicant, shareholders, officers or any staff members been subject to claims regarding rendered professional services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give full details:
Over the last five (5) years, did the applicant, shareholders, officers or any staff members have received verbal or written complaint of negligence regarding rendered professional services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details:

Limits required for Commercial General Liability	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000
Limits required for the error and omission on the treatment extension	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000
Deductible BI & PD	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000

<b>Covenant: Under penalty of forfeiture, the insured agrees to notify the insurer within 14 days, in case of suspension of his certification by the DHSS, if applicable, or in case of imposition of a provisional administration.</b>	
Insured's Signature:	Date :

**NOTE: WILL BE EXCLUDED CLAIMS ARISING FROM OR REPORTED FACTS AND THOSE ARISING FROM ACTS, ERRORS, OMISSIONS, ERRORS OR CIRCUMSTANCES KNOWN TO THE APPLICANT BEFORE THE EFFECTIVE DATE OF THE POLICY.**