

ALTERNATIVES RESSOURCES APPLICATION

Complementary application for Commercial General Liability and E&O.

☐ Senior residence

☐ Alternative resources

APPLICANT INFORMATION

1. Applicant's name:

2. Applicant's address:

3. Number of years as an owner or operator:

4. Number of years of experience in this business if the owner or operator for less than two years

5. Licence

☐ Municipal

☐ Health Quebec

☐ DHSS

6. Member of an association
If Yes, which one?

☐ Yes ☐ No

ACTIVITIES

7. Area: (pi ca)

8. Revenue:

\$

9. Payroll:

\$

10. Maximum capacity:
Current capacity:

11. Lease:

☐ Annual

☐ Monthly

☐ None

12. Number of resident per categories:

Independant living

Assistes living

Dependant living

13. Type of client:

☐ Women Shelter

☐ Drug addiction

☐ Aids

☐ Homelessness

☐ Youth

☐ Mental Health

☐ Alcohol addiction

☐ Handicapped

☐ Seniors

☐ Other:

14. Client age:

- ☐ 0 to 11yrs
☐ 19 to 64yrs

- ☐ 12 to 18yrs
☐ 65yrs and more

15. Number of employee by category:

Health Professionals

CPR and First Aid

Assistance to residents

Administration, office

Maintenance

Volunteers

Other: _____

16. Describe auditing measures when hiring a new employee:

17. Are a code of ethics and written policies in regard to physical and sexual abuse given to employees upon hiring?

☐ Yes ☐ No

CARE & DRUGS

1. Are drugs kept under lock and key?

☐ Yes ☐ No

2. Do you keep a registry of drugs?

☐ Yes ☐ No

If No, describe the preventive measures currently in place:

3. Are drugs kept under lock and key?

☐ Yes ☐ No

4. Are any non-prescription medication administered or distributed?

☐ Yes ☐ No

If Yes, what kind of drugs:

How Often:

Under what conditions are these drugs are distributed?

5. Are resident visited by a doctor?

☐ Yes ☐ No

If Yes, at what frequency:

6. Is nursing provided?

☐ Yes ☐ No

If Yes, indicate the frequency:

7. Is it provided by a person other than a nurse?

☐ Yes ☐ No

If Yes, explain:

8. Number of residents receiving the following treatments:
- | | |
|--|-------|
| Assistance for hygiene, food and clothing | _____ |
| Domestic Help Services (Housekeeping, groceries and others errands) | _____ |
| Residents Conditions (temperature, blood pressure, heartbeat, breathing and weight) | _____ |
| Administration of prescription drugs | _____ |
| Suivi à l'hygiène alimentaire ou assistance à la préparation des repas hygiene or assistance in preparing meal | _____ |
9. Description of activities offered on site:
- _____
10. Description of activities offered off site:
- _____
11. Are there any fundraising activities organized? ☐ Yes ☐ No
- If Yes, how often? _____
- Describe the type of activity: _____
- _____
12. Description additional services provided by your institution:
- _____
13. Swimming Pool on site ☐ Yes ☐ No
14. SPA or therapeutic baths ☐ Yes ☐ No
15. Elevator on site ☐ Yes ☐ No

PROTECTIONS

1. Number of exits per floors: _____
- Easily accessible? ☐ Yes ☐ No
2. Doors equipped with a panic bar? ☐ Yes ☐ No
3. Adequate smoke alarms? ☐ Yes ☐ No
4. Adequate smoke detectors? ☐ Yes ☐ No
5. Adequate portable fire extinguishers? ☐ Yes ☐ No
6. Fire alarm system? ☐ Yes ☐ No
7. Adequate emergency exit indicators? ☐ Yes ☐ No
8. Effective and satisfactory emergency lighting system? ☐ Yes ☐ No
9. Is cooking allowed in the rooms? ☐ Yes ☐ No
10. Can the beneficiaries smoke in their room? ☐ Yes ☐ No
11. Is there a lounge or lounges for smokers? ☐ Yes ☐ No

12. Evacuation plan on every floor easily seen? ☐ Yes ☐ No
13. Annual fire practice? ☐ Yes ☐ No
14. Bathrooms provided with support bars? ☐ Yes ☐ No
15. Bathrooms provided with nonskid surfaces? ☐ Yes ☐ No
16. Bathrooms provided with an emergency bell? ☐ Yes ☐ No
17. Is there a hoist for handicapped persons? ☐ Yes ☐ No
18. Are there any sprinklers? ☐ Yes ☐ No
19. Who can enter the building at night?

20. How does it work at night for the entrance doors?

HISTORIC

1. Over the past five (5) years, did an insurer refused to renew or cancelled a similar insurance policy? ☐ Yes ☐ No
2. Over the last five (5) years, did the applicant, shareholders, officers or any staff members been subject to claims regarding rendered professional services? ☐ Yes ☐ No
If Yes, give full details (Date, circumstances, amount paid, reserve, claim opened or closed):
3. 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? ☐ Yes ☐ No
If Yes, give details:

COVERAGES

Limits required for Commercial General Liability: \$ _____

Required deductible: \$ _____

Limits required for the Medical Malpractice \$ _____



Abuse coverage:

☐ Yes ☐ No

If Yes, please send a copy of the protocol and completed abuse application.

Limit:

\$ _____

Deductible:

\$ _____

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.

Note: Will be excluded claims arising from or reported facts and the those arising from acts, errors, omissions, errors or circumstances known to the applicant before the effective date of the policy.

Applicant's signature: _____

Date: _____

Please send the completed, signed and dated application to underwriting@revau.com.