MARSH

Marsh Canada Limited
120 Bremner, Suite 800
Toronto, Ontario M5J 0A8
Phone: 416 349 6697 / 1 888 768 9887
Fax: 416 815 3541 / 1 888 336 6629
Email: hscorp.service@marsh.com

HSC

Housing Services Corporation Insurance Program – New Business Application

GENERAL INFORMATION

Legal Name of Non-Profit Housing Corporation	HSC Number

Mailing address – Line 1

Mailing address – Line 2

City	Province	Postal Code

Contact Person	Position	Are you an external property manager?	

Phone	Fax	Email

Service Manager:		Housing Provider Type:	

Do you receive funding from:			
	Ministry of Health and Long-term Care	☐ Yes	☐ No
	Ministry of Children and Youth Services	☐ Yes	☐ No
	Ministry of Community and Social Services	☐ Yes	☐ No
	None of the above	☐ Yes	☐ No

Expiring Annual Premium $	Expiring Date (mm/dd/yyyy)

A. INSURED'S DETAILS

Do you have any fuel or oil storage tanks on any of your properties? (i.e.: for generators)
☐ Yes ☐ No

Do you require coverage to cover any leaks from those tanks? ☐ Yes ☐ No
If Yes, please contact Marsh for an application.

Are you planning any major renovations to your building or new construction during the next 24 months? ☐ Yes ☐ No

If Yes, please provide details, including estimated budget and proposed commencement date.

Do you have any unoccupied units? ☐ Yes ☐ No Indicate % of Unoccupancy
NOTE: a property is considered vacant when the entire building remains unoccupied for more than 30 consecutive days.

Address of vacant buildings:

If Yes, describe condition, time frame, action being taken?

B. CRIME

How many of your employees regularly handle money, securities or merchandise?

Is a security / police check carried out prior to employment? ☐ Yes ☐ No	Are all incoming cheques stamped "For Deposit Only?" ☐ Yes ☐ No

Is a countersignature required on all cheques? ☐ Yes ☐ No	Does the person who reconciles the bank accounts also: Sign cheques? ☐ Yes ☐ No Handle deposits? ☐ Yes ☐ No

Name of auditor or accountant:	How often is an audit made?

Does the auditor report directly to the entire Board? ☐ Yes ☐ No
If Yes, how often?

Maximum amount of money and securities on premises at any one time: $

Maximum amount of money and securities on premises overnight: $	Where is the money kept overnight?

If you have a safe or vault, provide make, model, type of lock, etc.:

C. BOARD MEMBERS / VOLUNTEERS ACCIDENT INSURANCE– OPTIONAL COVERAGE

Do you currently have this coverage? ☐ Yes ☐ No

If Yes or No and would like a quote, please contact Marsh for an application.

D. EXTERNAL PROPERTY MANAGER

Do you hire a Property Management Company to manage your properties? ☐ Yes ☐ No

If Yes, complete the following questions:

Do you obtain a certificate of insurance evidencing they maintain the following insurance: ☐ Yes ☐ No

Commercial General Liability Insurance for a minimum of $2,000,000? ☐ Yes ☐ No

Professional Liability / Errors and Omissions Insurance for a minimum of $2,000,000? ☐ Yes ☐ No

It is strongly suggested that you require them to carry these coverages. Please call 1-888-768-9887 to discuss further.

E. PROPERTY MANAGERS' ERRORS AND OMISSIONS

This section must be completed **ONLY** for Insured's who provide Property Management services to other Non-Profit Housing Corporations.

Do you require Property Managers' Errors and Omissions coverage for your property management services? ☐ Yes ☐ No

If Yes, you will need to complete the Property Managers' Errors and Omissions questionnaire.

Please indicate the categories that apply:

☐ General Administration ☐ Tenant Placement/Selection ☐ Financial Management ☐ Property Maintenance ☐ Property Management

Has your corporation previously carried Errors and Omissions insurance?

☐ Yes ☐ No

If Yes, provide the name of the Insurer and the policy term:

Has any previous carrier ever cancelled or refused to renew?

☐ Yes ☐ No

If Yes, for what reason?

Has any claim for professional services been made against your corporation during the past five years?

☐ Yes ☐ No

If Yes, please provide details:

Are you aware of any fact, error, omission or incident which may give rise to such a claim?

☐ Yes ☐ No

If Yes, please provide details:

Date of Loss (dd/mm/yyyy)	**Cause of Loss**	**Reserve Amount**	**Amount Paid**
		$	$
		$	$
		$	$

F. TENANT SUPPORT OR ASSISTED CARE SERVICES ERRORS AND OMISSIONS

Does your Non-Profit Housing Corporation provide any of the following Tenant Support or Assisted Care Services? ☐ Yes ☐ No

* Abused Women Shelters
* Elderly Care
*Life / Social Skills
* Physiotherapy
*Summer Camps
* After School Programs
* Employment Services
* Massage Therapy
* Pregnancy Counselling
* Vocational / Educational Services
*Assist in Personal Care
* Homeless Shelters
* Medical Services (incl. Health & Wellness services)
* Substance Abuse Treatment Centre
* Do you have Naloxone kits and do you have any staff
*Counselling Services
* Immigration Services
* Nursery Daycare

Do your employees or a contracted employee(s) provide any of these services?

☐ Yes ☐ No

If Yes, please describe:

Do you hire any outside company, other than staff or contracted employee(s) to provide Tenant Support or Assisted Care Services? Yes ☐ No ☐

If Yes, complete the following questions:

Do you obtain a certificate of insruance evidencing they maintain the following insurance: ☐ Yes ☐ No

Commercial General Liability Insurance for a minimum of $2,000,000? ☐ Yes ☐ No

Professional Errors and Omissions Insurance for a minimum of $2,000,000? ☐ Yes ☐ No

It is strongly suggested that you require them to carry these coverages. Please call 1-888-768-9887 to discuss further.

G. ABUSE COVERAGE

Do you require coverage? ☐ Yes ☐ No

If Yes, please complete the Abuse Questionnaire.

H. NON-PROFIT ORGANIZATION DIRECTORS' AND OFFICERS' LIABILITY
NOTE: ALL QUESTIONS MUST BE COMPLETED IN THEIR ENTIRETY

General Information

Describe the organization's legal structure (corporation, association, foundation, professional, trade or service, etc.), purpose(s) and the nature of operations.

Incorporated under the laws of:
Date:

Financial

Is the organization in arrears in its payments of monies payable to Revenue Canada or the provincial ministries of revenue (including source deductions, GST and PST)? ☐ Yes ☐ No

Is the organization currently or has it at any time during the past three years been in breach of any of its debt covenants, loan agreements, contractual obligations, or does it anticipate any such breach occurring within the next twelve months? ☐ Yes ☐ No

If Yes to (1) or (2), attach details. Estimated surplus or (deficit)	For the current year, indicate: Estimated revenues $

Operational Activities

Please provide the following information concerning the organization:

Total No. of employees	Total No. of volunteers

Does the organization or any person(s) proposed for this insurance perform the following? ☐ Yes ☐ No

If Yes, please explain.

Promote or sponsor any type of group travel, conventions, parades or other similar events, or assume any liability in connection within?
☐ Yes ☐ No

Act as or participate in a peer review group or committee for assessing the qualifications and performance of others or the quality of product manufactured, sold, handled or distributed by others? ☐ Yes ☐ No

Publish any magazines, periodicals or newsletters? If Yes, please attach copies. ☐ Yes ☐ No

Publish a technical manual? ☐ Yes ☐ No, If Yes, please attach copy.

Prior Directors' and Officers' Insurance

Has any similar insurance to that proposed herein been declined, cancelled or renewal thereof refused? ☐ Yes ☐ No
If Yes, please attach details.

Have any claims, or facts or circumstances which might reasonably give rise to a claim, been reported to the current or previous Directors' and Officers' Liability insurance carrier(s)? ☐ Yes ☐ No, If Yes, please attach details.

Previous Directors' and Officers' Liability insurance

Insurer(s)	Limit	Expiration Date	Retention	Premium
	$		$	$
	$		$	$
	$		$	$

Prior Knowledge

Has any claim been made or is any claim now pending against any director or officer of the organization or any other person(s) proposed for this insurance? ☐ Yes ☐ No

Has any suit or legal action been filed by or on behalf of the organization against any person(s) proposed for this insurance?
☐ Yes ☐ No

Has the organization within the last three years been the subject of any enquiries, complaints, notices or hearings by and federal or provincial regulatory authority? ☐ Yes ☐ No

Is the undersigned or any other person(s) proposed for this insurance aware of any fact or circumstance involving the organization, its subsidiaries or the directors or officers or the trustees, employees, volunteers or committee members of the organization or its subsidiaries which he/she has reason to believe might result in any future claim? ☐ Yes ☐ No

WITHOUT LIMITATION TO ANY OTHER REMEDY AVAILABLE TO THE INSURERS, THE PROPOSED INSURANCE WILL NOT AFFORD COVERAGE TO ANY CLAIMS OF WHICH ANY PERSON PROPOSED FOR THIS INSURANCE HAS KNOWLEDGE, NOR ANY CLAIMS RESULTING FROM ANY FACTS OR CIRCUMSTANCES OF WHICH ANY PERSON PROPOSED FOR THIS INSURANCE HAS KNOWLEDGE.

Attachments

The following documents will be required if binding coverage through Marsh Canada.

a) Insurers completed D&O application and Warranty Statement.
b) Latest annual report including audited financial statements.
c) Latest interim financial statement available.
d) Copy of the organization's by-laws and constitution.
e) Complete list of subsidiaries (any corporation of which the organization owns more than fifty percent (50%) of the voting stock and indicate if any operate for profit.
f) Complete list of duly elected or appointed directors / trustees and officers of the organization.
g) Complete list of committees responsible to the Board of Directors and provide a brief description of each committee's functions.

Note: With respect to (d), (e) and (f) above, notwithstanding the content of the lists submitted and subject to the terms and conditions of the proposed insurance, coverage will only be afforded to those companies and individuals that fit within the applicable policy definitions.

I. LOCATION PROPERTY INFORMATION
PLEASE COMPLETE AN ADDENDUM FOR EACH LOCATION

Name of location to be insured

Address of Location – Line 1

Address of Location – Line 2

City	Province	Postal Code

Please provide site plan and pictures (if available) of highest value project/building.

Project Design:

☐ Owned ☐ Leased

☐ Apartments	☐ Row Housing	☐ Stacked Row Housing	☐ Walk-Up
☐ Hostel/Hotel	☐ Single	☐ Semi-Detached House	☐ Other (Describe)

No. of buildings	No. of stories	Levels of underground parking
Year built	Original construction cost	Year of major renovation

What is the size of your property lot?	Please indicate the building square footage.

No. of units/beds:	☐ Family	☐ Single	☐ Senior	☐ Special

☐ Elevators How many? (include Service Elevators	☐ Air conditioning	☐ Central Air

Building Occupancy: %	Residential %	Commercial %	Assisted Senior / Disabled Units %
Nursery/Daycare %	Parking % Indicate if above or underground:		Unoccupied %

How long do you expect this location to be unoccupied?

Construction:

Floors:	☐ Concrete	☐ Wood Joist	☐ Steel Joist	☐ Not Applicable	
Walls:	☐ Concrete	☐ Masonry / Solid Brick	☐ Brick & Frame	☐ Frame or Wood	☐ Not Applicable
Roof:	☐ Concrete	☐ Steel Deck	☐ Frame or Shingles	☐ Not Applicable	
Heating:	☐ Boiler	☐ Natural Gas / Forced Air	☐ Electric	☐ Oil	☐ Other (Describe)

Have you done a Building Condition Audit (BCA)? ☐ Yes ☐ No	If Yes, Indicate Year
Have you done an Energy Audit? ☐ Yes ☐ No	If Yes, Indicate Year
Do you have a Building Value Appraisal? ☐ Yes ☐ No	If Yes, Indicate Year of Appraisal (Please attach copies):

Protection:	☐ Hydrants within 500 ft.	% Sprinklered	☐ Central Station Alarm	☐ Local Alarm	☐ Smoke Detector
	☐ Heat Detectors	☐ Smoke or heat detectors in each unit	☐ Smoke or heat detectors in common areas	☐ Security guards or guardian service	

Do your tenants pay for their own utilities? ☐ Yes ☐ No

If Yes,

Water	☐ Yes	☐ No
Electricity	☐ Yes	☐ No
Electric Heat	☐ Yes	☐ No
Natural Gas Electric Heat	☐ Yes	☐ No
Electric Heat	☐ Yes	☐ No

Is this a Smoke Free building? ☐ Yes ☐ No	Do you have a Smoke Free policy for new tenants? ☐ Yes ☐ No	Do you have a Fire / Evacuation Safety Plan? ☐ Yes ☐ No

Do you require tenants to carry tenant insurance? ☐ Yes ☐ No
If Yes, do you monitor for compliance? ☐ Yes ☐ No

Is the ENTIRE building outfitted with 'cook-top' safety elements? ☐ Yes ☐ No

Municipal Water Supply: Is Water Supplied By: ☐ Municipal ☐ Other	If Other, describe:

Do you require Non-Municipal Water Supply coverage? ☐ Yes ☐ No If Yes, please complete the Non-Municipal Water Supply Application.		
Property Values:	Building Replacement Cost $	Contents Replacement Cost $
	Annual rental income (assuming all units are at market rent) $	Annual additional business income $
	Please indicate the source of additional Income	Indemnity period required: ☐ 12 months ☐ 24 months

Additional Interests Associated For This Location

Additional Interest Name			
Address of Location – Line 1			
Address of Location – Line 2			
City	Province	Postal Code	
Additional Interest Type:	☐ Mortgagee	☐ Loss Payee	☐ Additional Insured
Interest with respect to:			

Additional Interest Name			
Address of Location – Line 1			
Address of Location – Line 2			
City	Province	Postal Code	
Additional Interest Type:	☐ Mortgagee	☐ Loss Payee	☐ Additional Insured
Interest with respect to:			

Additional Interest Name			
Address of Location – Line 1			
Address of Location – Line 2			
City	Province	Postal Code	
Additional Interest Type:	☐ Mortgagee	☐ Loss Payee	☐ Additional Insured
Interest with respect to:			

Additional Interest Name			
Address of Location – Line 1			
Address of Location – Line 2			
City	Province	Postal Code	
Additional Interest Type:	☐ Mortgagee	☐ Loss Payee	☐ Additional Insured
Interest with respect to:			

J. CURRENT INSURANCE

Please indicate which of the following types of insurance coverage you currently have and provide requested details:

Coverage	Policy Term	Policy No.	Insurer	Limit	Deductible
☐ Property				$	$
☐ Equipment Breakdown (Boiler & Machinery)				$	$
☐ Commercial General Liability				$	$
☐ Abuse				$	$
☐ Crime				$	$
☐ Directors' and Officers'				$	$
☐ Property Managers' Errors and Omissions				$	$
☐ Tenant Support or Assisted Care Services Errors and Omissions				$	$
☐ Automobile				$	$
☐ Garage Automobile				$	$
☐ Accidental Death & Dismemberment				$	$
☐ Other, Specify				$	$

K. NEW POLICY TERM INSURANCE

Please indicate your requested limits and deductibles for the new policy term:

Coverage	Limit	Deductible
☐ Property ☐ Equipment Breakdown (Boiler & Machinery)	Total Insured Values	☐ $5,000 ☐ $10,000 ☐ $25,000
☐ Commercial General Liability	$2,000,000	☐ $5,000 ☐ $10,000 ☐ $25,000
☐ Abuse	$2,000,000	10 % minimum of the loss or minimum of $5,000
☐ Crime – Employee Dishonesty	$250,000	NIL
☐ Crime – Money and Security	☐ $25,000 If higher limits are required, please advise:	NIL
☐ Directors' and Officers'	☐ $2,000,000 ☐ $3,000,000 ☐ $5,000,000 ☐ $10,000,000	NIL
☐ Property Managers' Errors and Omissions	$2,000,000	☐ $5,000 ☐ $10,000 ☐ $25,000
☐ Tenant Support or Assisted Care Services Errors and Omissions	$2,000,000	☐ $5,000 ☐ $10,000 ☐ $25,000
☐ Umbrella ☐ Automobile Excess Liability	$3,000,000 (Please indicate if you need a higher limit)	$10,000 SIR
☐ Board Member / Volunteers Accident (Accidental Death & Dismemberment)		

L. CLAIMS HISTORY

Have there been any losses in the last five (5) years? ☐ Yes ☐ No

If YES , please provide details of all losses in the last five years for all projects (include property, liability, boiler, crime). This information may be provided on a separate sheet

Date (mm/dd/yyyy)	**Cause of Loss**	**Reserve**	**Amount Paid**
		$	$
		$	$
		$	$
		$	$
		$	$

DECLARATIONS

The undersigned declares:

a) That he/ she is duly authorized to complete this application and that the statements set forth herein are true and complete.

b) That reasonable efforts have been made to obtain sufficient information from each and every person proposed for this insurance to facilitate the proper and accurate completion of this application form.

c) That the financial statements submitted with this application are representative of current financial position of the organization (if not provide details)

The undersigned declares:

a) That if the information supplied on this application changes between the date of this application and the effective date of the policy, he/she will provide written notice of such changes immediately to hscorp.service@marsh.com without limitation to any other remedy, HSC Insurance Inc or Marsh Canada Limited may withdraw or modify any outstanding quotations, and any authorization or agreement to bind coverage.

b) That should a policy be issued, this application and its attachments shall form part of the policy.

c) By signing this renewal application form, you consent to Housing Services Corporation, HSC Insurance Inc. and Marsh Canada Limited to collecting all the information about you arising out of the HSC Insurance Program for the purposes outlined in this paragraph. The information will be shared with current and proposed brokers and underwriters to the HSC Insurance Program. It will also be shared, on a confidential basis, with your municipal and/or dssab service manager(s) and used, on a non-identified basis, for risk management, service standards, new offerings, and sector or governmental analysis and compilation.

PRIVACY WORDING

PRIVACY: Have you read Marsh's Privacy Policy which is available at www.marsh.ca? Do you consent to the collection, use, disclosure and retention of your Personal Information as set out in the Privacy Policy, and do you understand that you may (subject to certain restrictions and consequences) later withdraw your consent as to any or all of the purposes identified in that Policy?

By signing this form you are consenting to the statements above.

SIGNATURE

Name of authorized officer, partner or principal (please print)	By typing your name here, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.
Title	
Date (mm/dd/yyyy)	

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HSC

Property Managers' Errors and Omissions Questionnaire

GENERAL INFORMATION

Legal Name of Housing Corporation		HSC Number
Mailing address – Line 1		
Mailing address – Line 2		
City	Province	Postal Code
Contact Person	Position	
Phone	Fax	Email

INSURANCE DETAILS

1. Does your Housing Provider perform any management activity on behalf of others?
☐ Yes ☐ No If Yes, please advise the total number of third party units serviced:

If Yes, please indicate all applicable categories:

☐ General Administration	☐ Financial Management	☐ Property Management
☐ Tenants Placement Selection	☐ Property Maintenance	☐ Other (Please Describe)

1. Has your corporation previously carried Property Managers' Errors and Omissions Insurance: ☐ Yes ☐ No
If yes, please provide:

Insurer Name:	Policy Term:

2. Has any previous insurer ever cancelled or refuse to renew your Property Managers' Errors and Omissions coverage?
☐ Yes ☐ No
If yes, please provide details:

3. Has any claim for professional property management service been made against your corporation within the past 5 years?
☐ Yes ☐ No
If Yes, please provide details:

4. Are you aware of any fact, error, omission or situation which may give raise to a professional liability claim?
☐ Yes ☐ No
If Yes, please provide details:

Date of Loss (dd/mm/yyyy)	**Cause of Loss**	**Reserve Amount**	**Amount Paid**
		$	$
		$	$
		$	$

PRIVACY WORDING

PRIVACY: Have you read Marsh's Privacy Policy which is available at www.marsh.ca? Do you consent to the collection, use, disclosure and retention of your Personal Information as set out in the Privacy Policy, and do you understand that you may (subject to certain restrictions and consequences) later withdraw your consent as to any or all of the purposes identified in that Policy?
By signing this form you are consenting to the statements above.

SIGNATURE

Name of authorized officer, partner or principal (please print)	By typing your name here, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.
Title	
Date (mm/dd/yyyy)	

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HSC

Tenant Support or Assisted Care Services Errors and Omissions Questionnaire

GENERAL INFORMATION

Legal Name of Housing Corporation		HSC Number
Mailing address – Line 1		
Mailing address – Line 2		
City	Province	Postal Code
Contact Person	Position	
Phone	Fax	Email

TENANT SUPPORT OR ASSISTED CARE SERVICES DETAILS

1. Indicate the number of people serviced annually, broken down by the following:

Abused Women Shelters	Assist in Personal Care	Elderly Care
Homeless Shelters	Life / Social Skills	Medical Services (incl. Health & Wellness services)
Physiotherapy	Substance Abuse Treatment Centre	Vocational / Educational Services
After School Programs	Counselling Services	Employment Services
Immigration Services	Massage Therapy	Nursery / Daycare
Pregnancy Counselling	Summer Camps	

2. Indicate the number of units used for:

Abused Women Shelter (number of rooms)	Abused Women Shelter (avg. length of stay)
Assisted Care (Elderly, disabled, etc.)	Homeless Shelter (avg. length of stay)

3. Indicate the number of employees providing this service:

Number of Councellors:

Number of Massage Therapists:

Number of Physiotherapists:

Number of Registered Nurses:

Number of external or Practitioner Nurse:

Number of Practical Nurse Assistant:

Other (ie Personal Support Workers):

4. Does your corporation provide services for abused women ☐ Yes ☐ No
If Yes, please indicate:

4.1. Does the shelter operate a hotline that victims of domestic abuse can call? ☐ Yes ☐ No	4.2. Are these phone lines manned by trained counselors? ☐ Yes ☐ No
4.3. Are these phone lines manned by volunteers? ☐ Yes ☐ No	4.4. Have volunteers received in-house training? ☐ Yes ☐ No
4.5. How much in-house training do they receive?	4.6. What do their duties include?
4.7. Confidential files and documents accessible to: ☐ all workers ☐ only those required	4.8. Upon being admitted to the shelter, are women clearly informed of the house rules and potential consequences of violating those rules? ☐ Yes ☐ No
4.9. Are there documented procedures and protocols given to all staff regarding the administration and caring of the residences? ☐ Yes ☐ No	
4.10. Do residents ever share rooms with other residents? ☐ Yes ☐ No	4.11. Are rooms kept unlocked? ☐ Yes ☐ No

4.12. Do you operate a daycare centre on site? ☐ Yes ☐ No	4.13. If Yes, who is responsible for supervising the children that are left in the shelter's care in their mothers' absence?
4.14. Are residents: ☐ Short Term ☐ Long Term ☐ Both	

5. Does your corporation provide assistance in personal care? ☐ Yes ☐ No
If yes, please indicate

5.1. Do you employ doctors, nurses, therapists, etc.? ☐ Yes ☐ No	5.2. Do you outsource the services of doctors, nurse therapists etc? ☐ Yes ☐ No	
5.3. Does the assisted living facility (ALF) ever plan outings where residents will be transported together or in small or large groups? ☐ Yes ☐ No	5.4. Are drivers of transport vehicles taught how to evacuate handicapped and wheelchair-bound passengers in a safe and efficient manner? ☐ Yes ☐ No	
5.5. In the clustered household arrangement, what is the total number of:	Private Apartments	Semi-Private Apartments
5.6. Does the facility have any independent residential units as part of its setup? ☐ Yes ☐ No	5.7. Are different tiers of care offered, depending on residents' needs? ☐ Yes ☐ No	

5.8. What indoor and outdoor features and amenities does the facility have as part of its setup?

5.9. Have emergency escape routes and a concise list of evacuation procedures prominently been posted in the corridors of all multiple-occupancy structures?: ☐ Yes ☐ No

5.10. How often are emergency evacuation drills conducted?

5.11. Are prescriptions for medications for residents only written by:
☐ personal physician ☐ qualified staff member

5.12. Does the insured's in-house training program cover the proper methods of handling, storing, treating (when necessary), and disposing of medical and biological wastes? : ☐ Yes ☐ No

5.13. If Yes, split out from the totals above:

a. How many people other than your tenants are served:

b. Do you serve:	i. Residential Occupancies: ☐ Yes ☐ No	ii. Commercial Occupancies: ☐ Yes ☐ No

c. Do you test or treat water for such other occupancies year round:
☐ Yes ☐ No If no, how many months of the year?

6. Does your corporation provide homeless shelter: ☐ Yes ☐ No
If Yes, please indicate:

6.1. Average number of beds occupied per night	6.2. Are food services provided?

6.3. Are any other services provided?

7. Does your corporation provide assistance to persons with substance abuse: ☐ Yes ☐ No
If Yes, please indicate

7.1. Do you employ doctors ☐ Yes ☐ No	7.2. Do you outsource the services of doctors? ☐ Yes ☐ No

7.3. Does facility treat: ☐ alcoholics ☐ substance abusers ☐ both

a. On what basis does facility treat patients?
☐ inpatient ☐ outpatients ☐ both

b. How often do workers or volunteers provide transportation for clients?
☐ daily ☐ weekly ☐ monthly ☐ do not provide transportation

c. Are detoxification services provided on site?
☐ Yes ☐ No

7.4. Are documented procedures and protocols given to all staff regarding the administration and caring of the residences?
☐ Yes ☐ No

7.5. Does the facility ever use prescription medications or opiate substitutes in treating patients?
☐ Yes ☐ No If yes:

a. Where are drugs kept on the premises?	b. Who has access to them?

7.6. How often are inventories taken?

7.7. Is facility properly licensed and certified according to the operational criteria in Canada?
☐ Yes ☐ No

7.8. Is facility accredited by: ☐ third-party ☐ independent accrediting organization ☐ Not Applicable
Are all professionals on staff properly licensed or certified in their respective specialty areas? ☐ Yes ☐ No

7.9. How much training do volunteers receive?	7.10. Who is responsible for overseeing their training?

7.11. Who has access to confidential client files?

8. Does any staff (other than professional) administer medications: ☐ Yes ☐ No
If Yes, please indicate

8.1. Number of Staff	8.2. Type of medication provided
8.3. Required training	8.4. No. of individuals to whom support services are provided

9. Is Professional Liability coverage required for any professional staff (other than medical):
☐ Yes ☐ No If Yes, please indicate

9.1. How many non medical staff?	9.2. Professional Designations

10. Does your corporation currently carry or have carried Tenant Support or Assisted Care Services Errors and Omissions insurance?:
☐ Yes ☐ No
If Yes, please indicate

Insurer Name	**Insured Limit**	**Deductible**	**Claims Made?** (Yes / No)	**Retroactive Date** (dd/mm/yyyy)	**Expiry Date** (dd/mm/yyyy)
	$	$	☐ Yes ☐ No		
	$	$	☐ Yes ☐ No		
	$	$	☐ Yes ☐ No		

11. Has any previous insurer ever cancelled or refuse to renew your Tenant Support or Assisted Care Services Errors and Omissions coverage?
☐ Yes ☐ No
If yes, please provide details:

12. Has the corporation or any of its principals, partners, officers, or directors been the subject of any disciplinary action by any governmental body or professional association within the last five (5) years? ☐ Yes ☐ No
If yes, please provide details:

13. Have any lawsuits or claims been made against the corporation, its predecessors, subsidiaries, partners, officers, or employees during the past five (5) years?: ☐ Yes ☐ No
If yes, please provide details, as well as details of actions that have been taken to minimize the chance of a similar claim(s).

Date of Loss (dd/mm/yyyy)	**Cause of Loss**	**Reserve Amount**	**Amount Paid**
		$	$
		$	$
		$	$

14. After enquiring, is the corporation firm or its partners, officers, employees or subsidiaries aware of any actual or alleged errors, omissions, offences or circumstances which may reasonably be expected to result in a claim being made against the applicant or any proposed insured person or entity?: ☐ Yes ☐ No

PRIVACY WORDING

PRIVACY: Have you read Marsh's Privacy Policy which is available at www.marsh.ca? Do you consent to the collection, use, disclosure and retention of your Personal Information as set out in the Privacy Policy, and do you understand that you may (subject to certain restrictions and consequences) later withdraw your consent as to any or all of the purposes identified in that Policy?

By signing this form you are consenting to the statements above.

SIGNATURE

Name of authorized officer, partner or principal (please print)	By typing your name here, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.
Title	
Date (dd/mm/yyyy)	

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MARSH

Marsh Canada Limited
120 Bremner, Suite 800
Toronto, Ontario M5J 0A8
Phone: 416 349 6697 / 1 888 768 9887
Fax: 416 815 3541 / 1 888 336 6629
Email: hscorp.service@marsh.com

HSC

Housing Services Corporation Insurance Program – Abuse Questionnaire

(to be completed only if Abuse Coverage is required)

GENERAL INFORMATION

Legal Name of Housing Corporation		HSC Number
Mailing address – Line 1		
Mailing address – Line 2		
City	Province	Postal Code
Contact Person		Position
Phone	Fax	Email

ABUSE DECLARATION FORM

(In this questionnaire, the term “abuse” means sexual, physical, emotional or psychological abuse, molestation or haassment, including corporal punishment).

1. Provide complete description of Applicant’s business or operations:

2. What procedures do you follow to screen prospective employees and volunteers?

3. a) Do you have a formal written policy that prohibits abuse?
   ☐ Yes ☐ No **If Yes, please attach copy.**

   b) Do you have formal written procedures for handling allegations or complaints of abuse?
   ☐ Yes ☐ No **If Yes, please attach copy.**

4. 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, attached full details.**

5. Give details of all claims arising from abuse made against you, your employees, or any other person associated with your organization during the past ten years.

6. Provide details of child abuse prevention and awareness training:

I/We declare that the statements made above 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.

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Fax: 416 349 4551 / 1 888 336 6629
Email: hscorp.service@marsh.com

HSC

Non-Municipal Water Supply Testing &Treatment Questionnaire

GENERAL INFORMATION

Legal Name of Housing Corporation		HSC Number
Mailing address – Line 1		
Mailing address – Line 2		
City	Province	Postal Code
Contact Person		Position
Phone	Fax	Email

NON MUNICIPAL WATER SUPPLY DETAILS

1. How many people does your source of drinking water serve in total?
   Residential   Other, please describe:
2. Does your source of drinking water supply other than just tenants of your building? ☐ Yes ☐ No
   If yes, split out from the totals above:
   a. How many people other than your tenants are served?
   b. Do you serve: i. Residential Occupancies: ☐ Yes ☐ No   ii. Commercial Occupancies: ☐ Yes ☐ No
   c. Do you test or treat water for such other occupancies year round? ☐ Yes ☐ No
      If No, how many months of the year?
3. Do you contract out your water testing / treatment services? ☐ Yes ☐ No
   If so:
   a. Name of Contractor:
   b. Describe their qualifications:
   c. Is a certificate of insurance obtained listing you as an Additional Insured on their policy: ☐ Yes ☐ No
   d. What limit of liability do they carry? $
4. Is ground water or surface water the source of the drinking water you test / treat? ☐ Yes ☐ No
5. Has your water treatment system been certified by a qualified engineer to meet the minumum requirements of the Ontario Safe Drinking Water Act (OSDWA)? ☐ Yes ☐ No **If Yes, please attach a copy of their report**
6. Describe procedures in place to ensure that the drinking water system is at all times operated in accordance to the OSDWA Sampling, Testing and Treatment requirements:
7. Do you have back-up procedures to ensure all required sampling, testing and treatment schedules are adhered to? ☐ Yes ☐ No
   If Yes, please describe:
8. Describe the qualifications of each person involved in the sampling, testing, treatment:
9. What is the name of the laboratory used to do water testing?
10. What are their qualifications?
11. How frequently do you report your sampling, testing and treatment results to the medical officer of health, or other ministry office?
12. Describe sampling, testing, treating recordkeeping procedures.
13. How long have you been responsible for maintaining the drinking water system of your community?
14. Have you had any adverse drinking water quality incidents? ☐ Yes ☐ No
    If Yes, please describe:

15. In the event of the water testing indicating that the drinking water system poses an imminent health hazard, who is responsible for immediately implementing the order to:

Report findings to the medical officer of health:	
Cease or restrict operations of the system:	
Ensure that users are notified:	
Provide an alternate supply of drinking water:	
Operate, maintain and repair the system as ordered by authorities:	
Sample, test, monitor and report with respect to the quantity and quality of the source water:	
Assess and report on the water system:	
Secure the water system as required until such time as the order is revoked or the system de-commissioned:	

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