

**HOSPITAL QUESTIONNAIRE**

**1. GENERAL INFORMATION:**

(a) DATE OF INFORMATION: \_\_\_\_\_

NAME OF HOSPITAL: \_\_\_\_\_

KEY CONTACT: \_\_\_\_\_

POSITION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Email/Website: \_\_\_\_\_

(b) BROKER NAME: \_\_\_\_\_

BROKERAGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Email/Website: \_\_\_\_\_

(c) Does your hospital currently have a risk management program in place? Yes  No

If no, do you plan to implement one? Yes  No

If yes, has the Risk Management Program received approval from the hospital's Board? Yes  No

Does your hospital have a functioning incident reporting system? Yes  No

(d) Does your Hospital currently have a functioning quality assurance program in place? Yes  No

***Please attach copies of above programs.***

Name of Risk Manager? \_\_\_\_\_

(e) Please indicate the number of members on the Hospital Board. \_\_\_\_\_

(f) What is your total budget for the next twelve months? \_\_\_\_\_

(g) Indicate your sources of income and the percentage of your total revenue generated from each.

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(h) Indicate all fundraising sources, including receipts and the frequency of the events during the year.

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(i) Is the hospital controlled by or in control of any subsidiary or related entities such as foundations, auxiliaries or profit making corporations for which coverage is required? Yes  No

*If yes, please complete the supplemental Hospital Foundation Questionnaire.*

(j) Who is your present insurer? \_\_\_\_\_

What is your expiry/renewal date? \_\_\_\_\_

Is your present insurer offering renewal? Yes  No

If no, why not? \_\_\_\_\_

If yes, are they restricting coverage in any way? Yes  No

If yes, why and how? \_\_\_\_\_

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## 2. LIABILITY:

(a) What limit of liability is requested? \$ 5 million, \$ 10 million, \$ 15 million, or higher (please specify)

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(b) Is your current Medical Malpractice Insurance written on an occurrence or claims-made basis?

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Please specify the dates when you were insured on a claims-made form:

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Is "prior acts" coverage required for the period you were insured on a claims-made form? Yes  No

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(c) Are you a member of the Association of Canadian Teaching Hospitals? Yes  No

If yes, are you an Active or Associate Member? \_\_\_\_\_

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(d) Under the Public Hospitals Act, how is your hospital classified? \_\_\_\_\_

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(e) Please specify the services provided according to the following classifications:

	Total # of Beds	Average Occupancy	Patient Days of Care
Obstetrics			
Surgical			
Medical			
Otolaryngology			
Urology			
Gastroenterology			
Ophthalmology			
Pediatrics			
Cardiology			
Intensive Care			
Psychiatry			
Oncology			
Rehabilitation			
Addiction			
Palliative Care			
Chronic Care			
Geriatrics			
Other - Please specify:			

If your hospital provides Obstetrical Services, please specify:

# of Births \_\_\_\_\_ # of Bassinets: \_\_\_\_\_ # of Incubators: \_\_\_\_\_  
annually

(f) Is the total number of beds expected to increase or decrease during the next twelve-month period? Yes  No   
If yes, please explain: \_\_\_\_\_

(g) Do you provide Outpatient Services? Yes  No   
If yes, please specify the types of services that you provide and the # of visits:

Outpatient Services	Total Number of visits
Day Surgery	_____
Emergency visits	_____
Ambulatory care admissions	_____
Clinic visits	_____

(h) Is the grand total of ambulatory care/out-patient visits expected to increase or decrease during the next twelve month period? Yes  No   
If yes, please explain: \_\_\_\_\_

(i) Do you provide home care services? Yes  No   
If yes, are these services provided by the Hospital resources or contracted out?

If provided by the Hospital, what was the total number of visits? \_\_\_\_\_  
(as at the most recent fiscal year end)

If these services are contracted out, do you enter into an agreement with the contractor requesting indemnity and evidence of liability insurance?

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- (j) What is the % of patients treated from outside Canada? \_\_\_\_\_  
 Is a Governing Law and Jurisdiction Agreement obtained in all cases? Yes  No
- (k) Are Ambulance Services a responsibility of the Hospital? Yes  No   
 If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (l) Describe any activities outside the standard practice of medicine or the rendering of medical services (e.g. rental of offices, pay parking, cafeteria, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_
- (m) Do all qualified medical staff, including any interns, residents, and fellows have CMPA coverage? Yes  No   
 If no, please describe alternative arrangements made and for whom these arrangements apply:  
 \_\_\_\_\_  
 \_\_\_\_\_
- (n) Is your hospital presently involved in clinical trials? Yes  No   
 Are independently sponsored clinical trials conducted at your facility? Yes  No   
 If yes, do you obtain Certificate of Insurance from the sponsor of the trial? Yes  No   
 If no, please describe alternative arrangements: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (o) Is your organization involved in the sales and/or manufacturing of products or services for use outside of the Hospital? Yes  No   
 If yes, please specify: \_\_\_\_\_  
 \_\_\_\_\_

What are the estimated annual gross receipts per service/product, categorized as follows (please attach additional sheets if required):

1. Service/Product:  
 Canada \$ \_\_\_\_\_ U.S. \$ \_\_\_\_\_ Other \$ \_\_\_\_\_
2. Service/Product  
 Canada \$ \_\_\_\_\_ U.S. \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

- (p) When was your latest survey completed by the Canadian Council on Health Services Accreditation (CCHSA)?  
 Date: \_\_\_\_\_  
 Period of Accreditation: \_\_\_\_\_ years  
 Has accreditation ever been refused, revoked, or suspended?  
 If yes, please explain (include dates):  
 \_\_\_\_\_  
 \_\_\_\_\_

- (q) If you provide Obstetrical Services, has your hospital implemented MORE<sup>OB</sup>? Yes  No   
 Are obstetrical staff trained in:  
 NRP Yes  No  ACoRN Yes  No   
 Other Yes  No  Please specify: \_\_\_\_\_

- (r) Does the hospital own or use an aircraft landing strip or helipad? Yes  No   
 If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_

(s) Who provides outside maintenance (regular and winter) to the hospital grounds, sidewalks and parking lots? If contracted out, is the liability also transferred through an agreement?

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(t) How many employees do you have? \_\_\_\_\_

*Please provide a breakdown of your employees by type, as follows:*

	<i>F/T</i>	<i>P/T</i>
Physicians		
Surgeons		
Interns/Residents		
Nurses (identify whether Registered, Acute Care, Graduate, Part-time or Other)		
Nursing Assistants		
Primary Care Nurse Practitioners		
Pharmacists		
Psychologists		
Social Workers		
Nursing Assistants		
Dentists		
Registered Nurses		
X-Ray Technicians		
Lab Technicians		
Ambulance Driver or Attendants		
Other Employees		

**(Note: The above numbers should ONLY include those professionals and doctors that are employed as Hospital staff.)**

What is your total annual payroll? \_\_\_\_\_

(u) How many volunteers do you have? \_\_\_\_\_

(v) Is Workplace Safety Insurance (WSIB) carried? Yes  No

If no, has alternate coverage been purchased? (Please specify) \_\_\_\_\_

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(w) Please indicate the number of medical and dental professionals with Hospital privileges?

Physicians: \_\_\_\_\_  
 Surgeons: \_\_\_\_\_  
 Dentists: \_\_\_\_\_  
 Midwives: \_\_\_\_\_  
 Other (please specify): \_\_\_\_\_

Do all dental staff and midwives have liability insurance coverage? Yes  No

If yes, do you obtain proof of liability coverage annually? Yes  No

If no, please describe alternative insurance arrangements made and for whom these arrangements apply:

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**3. ERRORS AND OMISSIONS AND CORPORATE INDEMNIFICATION COVERAGE:**

(This policy is only available to Incorporated Non-Profit Entities)

Do you require E&O and CIC coverage? Yes  No

**If "YES", please complete the E&O and CIC Proposal Form.**

**4. ENVIRONMENTAL IMPAIRMENT LIABILITY:**

(a) Does your organization have underground storage tanks? Yes  No

If yes, please provide details (i.e. number, age & content):

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(b) Does your organization have above ground storage tanks? Yes  No

If yes, please provide details (i.e. number, age & content):

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(c) Does your organization have an incinerator? Yes  No

If yes, is it currently in use? Yes  No

(d) Do you have any PCBs or Asbestos on premises? Yes  No

If yes, please specify where and describe:

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(e) Has there been any change in process during the last five years that has altered the risk of pollution? Yes  No

If yes, please provide detail:

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(f) Do you have an environmental safety committee or any employees vested with specific responsibility for environmental control? Yes  No

If yes, please describe their duties and to whom they report:

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(g) Has an environmental audit or survey of your premises or operations been conducted in the last five years?

Yes  No

If yes, please indicate when, by whom, and if a copy of the report is available:

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(h) What, if any, in-house provisions are made to recycle, reuse, or separate materials from process wastes?

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(i) Are you aware of any circumstances, which may reasonably be expected to give rise to a claim against you because of environmental impairment? Yes  No

If yes, please provide detail:

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(j) What limits of insurance are requested?

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**5. CRIME SECTION:**

(a) How many employees and volunteers who, as part of their regular duties, handle or have custody of money, securities or incoming/outgoing merchandise?

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(b) How many employees and volunteers who only occasionally handle or have custody of money, securities or incoming/outgoing merchandise?

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(c) How often are audits conducted? \_\_\_\_\_  
Do these audits include all premises? \_\_\_\_\_

(d) What auditing company do you use?

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(e) Do you have an internal audit department? Yes  No   
If yes, please describe.

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(f) Does a responsible individual (authorized senior level) identify sources of revenue regularly and review controls over receipt of such revenue?  
If no, please explain.

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(g) Are the systems controlling the disbursement of funds reviewed by a responsible official on a regular basis?  
Yes  No   
If yes, how often? / If no, please explain.

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(h) Is there a regular system of taking vacation for those people handling finances? Yes  No   
If no, please explain.

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(i) Are receipts issued for all donations and are they controlled and reconciled to the deposits? Yes  No   
If yes, are the receipts sent out by the same person who collects the donations? / If no, please explain.

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(j) Are countersignatures required on all cheques? Yes  No   
If no, please explain:

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(k) Is a cheque-signing machine used? Yes  No

If yes, please explain controls.

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(l) Is there control over blank cheques? Yes  No

If yes, please describe:

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(m) Are bank accounts reconciled by someone not authorized to deposit or withdraw? Yes  No

If no, please explain:

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(n) Does someone outside of Accounts Payable confirm the correctness of all invoices paid?

Are these invoices stamped "Paid" at the time the cheques are issued to prevent duplicate cheques from being issued to fictitious persons?

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(o) Are securities subject to joint control? Yes  No

If no, please explain:

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(p) How often is inventory done?

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(q) What is the usual maximum amount of cash on the premises? \_\_\_\_\_

Are there any occasions when this amount is substantially higher? Yes  No

If yes, please explain:

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(r) What are your desired limits of coverage?

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**6. NON-OWNED AUTOMOBILE:**

(a) How many employees and volunteers drive their own personal vehicles on behalf of the Hospital (other than driving to and from work)?

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(b) Does the Hospital ever rent vehicles for short periods of time? Yes  No

If yes, please specify when and how often:

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(c) Do you operate ambulance services with non-owned vehicles?

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**7. AUTOMOBILE:** If more than five (5) vehicles, please complete the Fleet Supplemental questionnaire.

(a) Do you own or lease any vehicles? Yes  No

If yes, please provide a complete list providing full details concerning Year, Make, VIN #, RIN #, Seating Capacity, Use, and List Price (New) for each vehicle.

Year	Make	VIN#	RIN#	Seat Capacity	Use	List Price (New)

(b) Please indicate which vehicles, if any, are designated for the sole use of any one person as a business and pleasure vehicle (Company car).

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(c) Advise what automobile coverage, limits and deductibles are required (MINIMUM \$ 1,000. All Perils, \$ 1,000. Collision, \$ 500. Comprehensive):

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**8. GARAGE/PARKING LOT:**

(a) Do you own a pay-for-parking lot or garage? Yes  No

If yes, is the operation and management contracted out? Yes  No

If yes, to whom?

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(b) Identify how many spaces are in each parking facility.

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(c) What security arrangements have been made? Please identify.

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**9. PROPERTY SECTION:**

(a) Please provide a complete list of BUILDINGS, CONTENTS AND EQUIPMENT indicating **REPLACEMENT COST VALUES** for insurance **ON A PER LOCATION BASIS:**

NOTE: Please indicate separate values between contents, playground equipment and fencing.

(Attach a separate list if there is not enough space below)

	<u>OCCUPANCY</u>	<u>OWN RENT LEASE</u>	<u>ADDRESS</u>	<u>BUILDING VALUE</u>	<u>CONTENTS/EQUIPMENT VALUE</u>	<u>MAXIMUM NUMBER OF VEHICLES *</u>
1						
2						
3						
4						

\* For underwriting/reinsurance purposes, please identify the maximum number of vehicles in a specific building at any one time.

NOTE: If more than 1 location is listed, are any locations within 100 feet of each other? Yes  No

If YES, what is the exact distance? \_\_\_\_\_

Complete a copy of the attached **Risk Management/Inspection Services form** for each location. This will provide us with complete underwriting details.

Identify all Loss Payees/Mortgagees and indicate which locations they correspond to:

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Please identify all high value equipment (e.g. MRIs, Catscans, etc.)

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Is any construction planned in the next twelve months?

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**(b) DATA PROCESSING INSURANCE: (Complete if Computer BREAKDOWN coverage is required)**

Location		Equipment/Hardware Replacement Cost	Lap Tops/ Notebooks Replacement Cost	Media/Software Replacement Cost	Data Processing Extra Expense
Occupancy	Address				
1.					
2.					
3.					
4.					
<b>TOTALS:</b>					

(c) Are ALL locations and values included in the above sections (a) and (b), which are owned, leased, rented or under the control of the Insured? Yes  No

If "NO", please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(d) Specify preferred deductible: \$ \_\_\_\_\_ (MINIMUM \$ 5,000.)

**10. OTHER PROPERTY EXPOSURES:**

Do you require any special/additional property coverage/protection (such as fine arts, flood & earthquake, rental income, profits, gross earnings, gross revenues, tuition fees, etc.)? Yes  No

If "YES", please advise what coverage is required and the limit/amount ON A PER LOCATION BASIS:



**11. BOILER AND MACHINERY (MACHINERY BREAKDOWN):**

**Coverage required:** Comprehensive  Equipment Breakdown Protection

**NOTE:** *If Equipment Breakdown Protection required, what is the replacement value of the electronic equipment?*

\$ \_\_\_\_\_

(a) Do any locations contain central air conditioning units or pressure units? Yes  No

If "YES", please advise which locations and type of equipment: \_\_\_\_\_

\_\_\_\_\_

(b) Specify preferred deductible: \$ \_\_\_\_\_ (MINIMUM \$1000)

(c) Please provide a contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

**NOTE:** A full risk inspection will be done by Boiler Inspectors of all properties listed.

**12. CLAIMS HISTORY:**

*Please indicate the types of claims incurred over the past five years. Incurred claims would include all payments plus a reserve for outstanding claims.*

YEAR	TYPE OF CLAIM	AMOUNT PAID	RESERVE FOR UNPAID CLAIM

Is the applicant aware of any facts or circumstances, which may reasonably give rise to a claim, other than advised above?

Yes  No  If yes, please attach.

(a) Have all incidents been reported to the current insurer? Yes  No

# Risk Management/Inspection Services – please complete for each building

Insured: \_\_\_\_\_

Occupancy: \_\_\_\_\_

Location: \_\_\_\_\_

Municipal Protection	
Full Time Brigade	
Volunteer Brigade	
Miles to Fire Hall	
Hydrants >6"	

Building Protection	
Standpipes	
Siamese Connectors	
Extinguishers	
Fire Blankets	
Auto Wc/Dc/Co2	
Fire Doors	
Emergency Lighting	
Exit Signs	

Security	
24 Hr Occupancy	
Watchman Service	
Fenced Premises	
Exterior Lighting	

Alarms	Loc.	Mon
Smoke Detectors		
Heat Detectors		
Pull Stations		
Intrusion Alarm		
Surveillance Cameras		

Sprinklers	Loc.	Mon
Wet System		
Dry System		
% of Building		

General Information	
Year Built	
Height	
Dimensions	
Gross Area	
Est. Value	
Heritage Designation	

Construction Details					
Exterior Walls		Interior Walls		Finish	
Poured Concrete		Poured Concrete		Drywall	
Precast Concrete		Precast Concrete		Plaster	
Stone		Stone		Glazed Tile	
Brick on Block		Brick on Block		Metal	
Solid Brick		Solid Brick		Wood (T & G)	
Concrete Block		Concrete Block		Panelled	
Brick Veneer		Brick Veneer		Plywood	
Steel on Steel		Metal Stud		Aspenite	
Heavy Timber		Heavy Timber		Wallpaper	
Metal Clad/Frame		Wood Stud		Paint	
Frame		None		None	

Roof		
Style	Structural Members	Decking
Peak	Steel Joists	Concrete
Sloped	Laminated Beams	Steel
Flat	Heavy Timber	Mill >2"
Dome	Wood Joists	Wood
		Aspenite

Floors	
Concrete	
Wood	
Asphalt	
Gravel	
Dirt	
# of Elevators	

Finish	
Terrazzo	
Ceramic Tile	
Hardwood	
Carpet	
Vinyl Tile/Linoleum	
Paint	
None	

Ceilings	
Acc/Susp Tile	
Plaster	
Drywall	
Metal	
Wood (T & G)	
Plywood	
Aspenite	
Open to Deck	

Boiler Room	
Hot Water	
Steam	
Floor	
Walls	
Ceiling	
Door Closure	
Door Class	

H.V.A.C.	
Heat Pump	
Forced Air	
Elec. Baseboards	
Unit Heaters	
Infra-Red Radiant	
Central Air (BTU's)	
Air Exchange Units	

Electrical	
Conduit	
Bx	
Romex	
Breakers	
Fuses	
Borrowed	
Back-up Generator	
Transformers	

Comments: \_\_\_\_\_

Inspector: \_\_\_\_\_

Date: \_\_\_\_\_



**DIAGRAM** - Please draw buildings below, label and give exact distance between each for underwriting/reinsurance purposes.

**Location:** \_\_\_\_\_

N  
W + E  
S

