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UMBRELLA LIABILITY APPLICATION - HOSPITAL

Agency:

Date:

GENERAL INFORMATION

Name of Applicant, including all subsidiary companies, domestic and foreign:

Applicant is: A Corporation [] A Partnership [] An Individual [] or Other []

Address:

Other Locations:

Give complete description of all operations:

Annual Payroll \$ _____ Annual Sales/Receipts \$ _____ No. of Employees _____

Are any additional operations or locations anticipated during the policy period? Yes [] No []
If yes, explain:

Are all locations and operations to be covered? Yes [] No [] If no, explain:

Policy period desired: From _____ To _____

Limit of Liability: a) _____ in excess of underlying or retained limit.
b) _____ retained limit (self insured retention - must not be less than \$10,000.)

PREVIOUS UMBRELLA CARRIER

- a) Name of Carrier:
b) Has any carrier cancelled, declined or refused coverage in past 3 years?
Yes [] No [] If yes, explain:

DESCRIPTION OF EXPOSURES

AUTOMOBILE LIABILITY

a) State number of units owned and leased and registered in the name of the Applicant:

Private Passenger _____ Light Trucks _____ Heavy Trucks _____

Tractors _____ Trailers _____ Buses _____ (Seating Capacity _____)

b) Are flammable, explosive or toxic materials hauled? Yes No If yes, explain:

c) Are any units engaged in long haul (over 100 miles)? Yes No If yes, explain and state number of units:

d) In which Province(s) are vehicles chiefly garaged?

GENERAL LIABILITY

a) Does the underlying policy have the following extensions?

	YES	NO		YES	NO
Occurrence Property Damage	<input type="checkbox"/>	<input type="checkbox"/>	Employer's Liability	<input type="checkbox"/>	<input type="checkbox"/>
Broadform Property Damage	<input type="checkbox"/>	<input type="checkbox"/>	Contingent E.L.	<input type="checkbox"/>	<input type="checkbox"/>
Blanket Contractual Liability	<input type="checkbox"/>	<input type="checkbox"/>	Non-Owned Automobile	<input type="checkbox"/>	<input type="checkbox"/>
Personal Injury	<input type="checkbox"/>	<input type="checkbox"/>	Tenant's Fire Legal Liability	<input type="checkbox"/>	<input type="checkbox"/>
Employees as Additional Insureds	<input type="checkbox"/>	<input type="checkbox"/>	Blasting	<input type="checkbox"/>	<input type="checkbox"/>
Products/Completed Operations	<input type="checkbox"/>	<input type="checkbox"/>	Underpinning	<input type="checkbox"/>	<input type="checkbox"/>
Vendor's Endorsement	<input type="checkbox"/>	<input type="checkbox"/>	Collapse	<input type="checkbox"/>	<input type="checkbox"/>

b) Describe specifically the Products and/or Completed Operations and give sales for each:

c) Have any products been discontinued during the past 5 years? Yes No If yes, list products and reasons:

d) Are any products used or installed in any aircraft or missile? Yes No If yes, explain:

e) Does applicant have any sales to the U.S.? Yes No Does applicant have any sales to countries elsewhere?

Yes No If yes, Amount _____ Country and Product description: _____

f) Does applicant sell or distribute products of any foreign manufacturers? Yes No

If yes, specify product and country of origin:

g) Attach sales brochure or advertising material if available.

h) List principal customers:

i) List operations performed by independent contractors. State percentage of total receipts:

NON-OWNED PROPERTY – CARE, CUSTODY AND CONTROL

a) List all leased real properties:

LOCATION

OCCUPANCY

ESTIMATED VALUE

b) List all other property in the care, custody or control of applicant.

(Include such property as electronic equipment, leased automobiles, machinery, material on consignment, under bailment, property stored, etc.):

LOCATION

TYPE

ESTIMATED VALUE

AIRCRAFT AND WATERCRAFT:

List and describe any owned, non-owned, leased or chartered aircraft and watercraft:

WORKER'S COMPENSATION:

a) Are all employees covered by Workplace Safety and Insurance Board? Yes No If no, explain:

b) If not, is Employer's Liability carried on those employees not covered by Workplace Safety and Insurance Board? Yes No

PROFESSIONAL LIABILITY:

a) Is there any professional or errors or omissions exposure? Yes No If yes, explain:

b) Is there any incidental malpractice exposure? If yes, is it covered by underlying policies?

ADVERTISING LIABILITY:

a) Is any advertising contemplated during the policy term? Yes No If yes, explain type and state expenditure.

b) Is an advertising agency used? Yes No

CONTRACTUAL LIABILITY:

Give details of agreements in which the applicant assumes the liability of others:

RAILROAD OPERATIONS:

Give details of any Railroad owned, maintained or operated by applicant:

HOSPITAL LIABILITY QUESTIONNAIRE AND SCHEDULE OF WARRANTIES

A. Name of Hospital _____
Street Address _____

City _____ Province _____ Postal Code _____

B. PREMISES COVERAGE

Location _____

Construction _____ Age of Building _____

Total Floor Area _____ square feet.

Number and Type of Elevators _____

Is a Nurses' Residence operated by the Hospital? _____

If yes, Location _____

Area _____ square feet.

Description and Location of Other _____

Premises owned and/or occupied by the Hospital _____

C. PROTECTIVE COVERAGE

Anticipated Cost of Construction over next 3 Years _____

Will Contractors be required to file Proof of Adequate Public Liability Insurance with the Hospital? _____

D. MALPRACTICE COVERAGE

<p>1. Number of Beds Maintained</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">Medical/ Surgical</td> <td style="width: 33%; text-align: center;">ICU/RC U</td> <td style="width: 33%; text-align: center;">Palliative Care</td> </tr> </table>	Medical/ Surgical	ICU/RC U	Palliative Care	<p>2. Average Number of Beds used by Patients during last Fiscal Year</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">Medic al/ Surgic al</td> <td style="width: 33%; text-align: center;">ICU/RC U</td> <td style="width: 33%; text-align: center;">Palliativ e Care</td> </tr> </table>	Medic al/ Surgic al	ICU/RC U	Palliativ e Care
Medical/ Surgical	ICU/RC U	Palliative Care					
Medic al/ Surgic al	ICU/RC U	Palliativ e Care					

<p>3. Number of Bassinettes Maintained</p> <p>_____</p>	<p>4. Average Number of Bassinettes used by Patients during last Fiscal Year</p> <p>_____</p>
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5. Number of Outpatients per year

6. Number of Salaried Persons employed by the Hospital in each of the following Classifications:

- | | | |
|---------------------|----------------------------|--|
| a) Physicians _____ | e) Externes _____ | i) Pharmacists _____ |
| b) Surgeons _____ | f) Psychiatrists _____ | j) Graduate Nurses _____ |
| c) Dentists _____ | g) X-Ray Technicians _____ | k) All other Nurses including Student Nurses _____ |
| d) Internes _____ | h) Laboratory Techn. _____ | i) Paramedics _____ |

7. Is home care service provided by the hospital? _____

8. Does the hospital provide ambulance services? _____

9. Are the following Patients treated:

- a) Communicable _____ b) Tubercular _____ c) Mental _____

10. Is X-Ray used for
Diagnosis? _____ Treatment? _____

11. Number of physicians employed by the Hospital using X-Ray, Infra-Red Ray, Diathermy or Quartz Lamp for:

- a) Diagnosis and Treatment _____ b) Treatment Alone _____

12. Number of Technicians: _____

(The term "Technician" refers to persons giving or assisting in giving X-Rays, Infra-Red Ray, Diathermy or Quartz Lamp or Radium Treatment, Laboratory Technicians, Pharmacists and Ambulance Drivers employed by the Hospital).

13. Are Radium Treatments given by the Hospital? _____

14. Number of Radiologists administering Radium Treatment _____

15. Does the Hospital own
borrow
or rent radium?

16. Details of other Radioisotopes used by the Hospital:

E. PARTICULARS OF ALL CLAIMS IN THE PAST 5 YEARS:

Date: _____ Signed _____

Title _____