



Frank Cowan Company Limited
4 Cowan Street East
Princeton, ON N0J 1V0
www.frankcowan.com
Toll Free: 1-800-265-4000
Phone: 519-458-4331 Fax: 519-458-4366

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:

UNDERLYING INSURANCE

TYPE	CARRIER	POLICY NO.	POLICY PERIOD	POLICY LIMITS	ANNUAL PREMIUM
Auto					
C.G.L.					
Non-Owned Auto					
Employer's Liability					
Professional Liability					
Advertising Liability					
Contractual Liability					
Tenants' Legal Liability					
Other Non-Owned Property					

Does any Policy listed above contain:

1. A Deductible? Yes No
2. A reduced limit of liability for any exposure? Yes No
3. A territorial restriction, e.g., U.S. products? Yes No

If yes to any of the above, provide details:

LOSS HISTORY

Describe all losses paid or reserved over \$ 5,000. occurring during the past 5 years:

Signature _____

Date _____

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;">_____</td> <td style="width: 33%; text-align: center;">_____</td> <td style="width: 33%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center; font-size: small;">Medical/ Surgical</td> <td style="text-align: center; font-size: small;">ICU/RCU</td> <td style="text-align: center; font-size: small;">Palliative Care</td> </tr> </table> <p>3. Number of Bassinets Maintained</p> <p>_____</p> <p>5. Number of Outpatients per year</p> <p>_____</p>	_____	_____	_____	Medical/ Surgical	ICU/RCU	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;">_____</td> <td style="width: 33%; text-align: center;">_____</td> <td style="width: 33%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center; font-size: small;">Medical/ Surgical</td> <td style="text-align: center; font-size: small;">ICU/RCU</td> <td style="text-align: center; font-size: small;">Palliative Care</td> </tr> </table> <p>4. Average Number of Bassinets used by Patients during last Fiscal Year</p> <p>_____</p>	_____	_____	_____	Medical/ Surgical	ICU/RCU	Palliative Care
_____	_____	_____											
Medical/ Surgical	ICU/RCU	Palliative Care											
_____	_____	_____											
Medical/ Surgical	ICU/RCU	Palliative Care											

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 _____