

Toronto Office: 18 King St. E., Suite 300 Toronto, ON M5C 1C4
T: 416-603-7864 or 1-877-603-7864 | F: 416-603-7861 | www.suminsurance.ca

Montreal Office: 1001 De Maisonneuve Blvd. W., Suite 900 Montreal, QC H3A 3C8
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APPLICATION – ABUSE

This is an application for claims-made coverage with defense expenses included within the limits of insurance.

Name of Applicant: _____

Address of Applicant: Street _____
(Mailing address) City _____
Province _____ Postal code _____

Include Applicant's Website and/or email (if applicable): _____

Description of Operations: _____

DEFINITION:

Wherever used in this application form, "**Abuse**" means any act or threat involving molestation, harassment, corporal punishment or any form of physical, sexual or mental abuse.

1. POLICIES AND PROCEDURES	
Are abuse and neglect laws reviewed with all new employees and volunteers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the organization have a designated abuse prevention committee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the organization have a written policy with regard to abuse and abuse prevention?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has it been reviewed and approved by legal counsel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this policy reviewed in detail with all employees, volunteers or any person acting on behalf of the insured that have client contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. POLICIES AND PROCEDURES CONTINUED	
Does this policy include:	
Requirements for reporting all incidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A formal abuse response procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Detailed investigation procedures with regard to incidents or abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The requirement to report all incidents related to an actual or suspected abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The requirement that more than one employee or volunteer is present at all times that clients are in the organization's care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Procedures for monitoring new employees and volunteers during client contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are all employees and volunteers trained in recognizing possible abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. PLEASE PROVIDE US WITH A COPY OF THE WRITTEN PROCEDURES IN PLACE WITH RESPECT TO:	ATTACHED	N/A
The screening procedures for new employees (including leased and temporary workers), or volunteers (Example: Interview process, background checks, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
The procedures in the prevention of "abuse"	<input type="checkbox"/>	<input type="checkbox"/>
Initial and ongoing training of employees (including leased and temporary workers) and volunteers	<input type="checkbox"/>	<input type="checkbox"/>
Investigation procedures on abuse or allegations including reporting procedures and management	<input type="checkbox"/>	<input type="checkbox"/>

How long have these procedures been in place: _____

How does the applicant make sure the procedures are understood and adhered to:

3. OVER THE PAST TEN YEARS:

Have there been any claims or lawsuits arising from "abuse" made against any applicant(s) or any other person associated with the organization: Yes No If Yes, provide all the details and describe any change to procedures adopted as a result:

Have there been any allegations or incidents made against any applicant(s) or other person associated with the organization? Yes No If Yes, provide all the details:

4. EMPLOYEE/VOLUNTEER DETAILS:

Please identify the number of employees or volunteers with exposure to vulnerable persons and the nature of their involvement with these persons:

Care or care service provided to: Children: Yes No Number per day: _____
 Adults: Yes No Number per day: _____
 Disabled: Yes No Number per day: _____

5. PREVIOUS "ABUSE" INSURANCE

INSURER	LIMIT	PERIOD	CLAIMS MADE	OCCURRENCE
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	

This application and any supplements attached hereto do not bind the Applicant or the Company to complete this insurance but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

THE UNDERSIGNED HEREBY ACKNOWLEDGE THE TRUTH OF THE STATEMENTS CONTAINED HEREIN. I AUTHORIZE YOU TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION AS PERMITTED BY LAW, IN CONNECTION WITH MY/OUR COMMERCIAL INSURANCE POLICY OR A RENEWAL, EXTENSION OR VARIATION THEREOF, FOR THE PURPOSES NECESSARY TO ASSESS THE RISK, INVESTIGATE AND SETTLE CLAIMS, DETECT AND PREVENT FRAUD AND DETERMINE CLAIMS HISTORY.

Signature of Applicant: _____ Dated: _____

Print Name and Title: _____

BROKER NAME: _____

ADDRESS: _____

PHONE NO: _____

FAX NO: _____

EMAIL ADDRESS: _____



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