



# Care Liability

*Aged Care Providers Combined Liability*

*Application Form*

V0823

NOTE: If your business provides services to the Aged at home or within the Community ONLY and you do not operate an Aged Care Facility or Retirement Village, please complete the Home & Community Care Providers proposal

*This pdf document is fillable for your convenience*

# Important Notices

## YOUR DUTY OF DISCLOSURE

Before you enter into an insurance contract, you have a duty to tell the Insurer anything that you know, or could reasonably be expected to know, may affect the Insurer's decision to insure you and on what terms.

You have this duty until the Insurer agrees to insure you. You have the same duty before you renew, extend, vary or reinstate an insurance contract.

You do not need to tell the Insurer anything that:

- reduces the risk the Insurer insures you for; or
- is common knowledge; or
- the Insurer knows or should know as an insurer; or
- the Insurer waives your duty to tell the Insurer about.

### If you do not tell the Insurer something

If you do not tell the Insurer anything you are required to, the Insurer may cancel your contract or reduce the amount the Insurer pays you if you make a claim, or both.

If your failure to tell the Insurer is fraudulent, the Insurer may refuse to pay a claim and treat the contract as if it never existed.

## CLAIMS MADE SECTIONS

Sections Two and Three of the Policy are issued on a claims made and notified basis. This means that Sections Two and Three of the Policy only cover the Insured for claims first made against the Insured during the Period of Insurance and notified to the insurer during the Period of Insurance or the Extended Notification Period, whichever is applicable.

Section 40(3) of the Insurance Contracts Act 1984 may provide additional rights at law. That section provides that where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but during the period of insurance, the insurer is not relieved of liability under the contract in respect of the claim, when made, by reason only that it was made after the expiration of the period of insurance.

## RETROACTIVE DATE

Section Two of the Policy does not provide cover in relation to the conduct of the Aged Care Provider prior to the Retroactive Date.

Section Three of the Policy does not provide cover in relation to Wrongful Acts committed or alleged to have been committed prior to the Retroactive Date.

## PRIVACY

Pen Underwriting and the Insurer (referred to together in this Privacy Statement as 'We', 'Our' 'Us') handle your personal information with care and in accordance with the Privacy Act 1988 and the Australian Privacy Principles. We collect personal information about you to provide you with insurance and insurance related services. We may disclose your personal information to third parties for the purposes described in our Privacy Policy, including related entities, insurers, reinsurers, agents and service providers, some of whom may be located in the United States of America, United Kingdom, Singapore, Germany, Sweden and India. By asking us to provide you with insurance and insurance related services, you consent to the collection, use and disclosure (including overseas disclosure) of your personal information for the purposes described in our Privacy Policy. Where you provide personal information about others, you represent to us that you have made them aware of that disclosure and of our Privacy Policy and that you have obtained their consent. If you do not consent to provide us with the personal information that we request, or withdraw your consent to the use and disclosure of your personal information at any stage, we may not be able to offer you the products or provide the services that you seek. For information about how to access and or correct the personal information we hold about you or if you have any concerns or complaints, ask us for a copy of our Privacy Policy or visit [www.penunderwriting.com.au](http://www.penunderwriting.com.au).

# Instructions

Please download and save this PDF to your desktop and open via Adobe Acrobat to fill out digitally. Filling the form out in your browser will not save your answers.

- Answer all questions in full. Where appropriate, tick the 'Yes' or 'No' box that best indicates your reply.
- If there is insufficient space, provide further information in the additional information section.
- All attached documents form part of this Application Form.

This application is for         New Business                 Renewal - Policy Number (if known) is: .....        

The Definition of Named Insured in the policy includes the Insured named below and any subsidiary /company (including subsidiaries thereof) therefore there is no need to list subsidiaries. You are however required to declare all business activities and turnover for your entire business, including all subsidiaries for which coverage is proposed.

1. Please provide details of the Named Insured including trusts and/or trading names:

Name of Company	Does this Company provide care services	Does this Company employ their own staff	NDIS / ACQSC Registered
	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No
If any of the entities noted above have answered NO to all questions please provide details of the business activities of that insured			

2. Do you operate a service company that employs staff and then on-hires them or places them in companies within the group of companies owned/operated by you? Yes No  
 If Yes please provide details: .....

3. Please provide website: www .....

4. Are you registered for GST purposes? Yes No  
 ABN:..... Income Tax Credit: .....

5. Are your insurance premiums stamp duties exempt? Yes No  
 If Yes, please attach a copy of your Stamp Duty Exemption

6. Date Business Established: .....  
 If less than 2 years, please attach a Curriculum Vitae for each Director.

7. Has the Business ever traded under a different name? Yes No  
 If Yes, please provide details: .....

8. Has the Business ever been involved in a Merger/Takeover/Acquisition? Yes No  
 If Yes, please provide details

Name of Company	Date of Merger Takeover/ Acquisition	Did Merger Takeover/ Acquisition include the liabilities
		Yes No
		Yes No
		Yes No

9. Does the Business envisage any changes in ownership in the next 12 months? Yes No  
 If Yes, please provide details:  
 .....

10. Have you ever had an Insurer:
- |                                    |     |    |
|------------------------------------|-----|----|
| a) Decline a proposal              | Yes | No |
| b) Impose special terms            | Yes | No |
| c) Decline to renew your insurance | Yes | No |
| d) Cancel your insurance           | Yes | No |
- If Yes, to any of the above please provide details:
- .....

11. Has any owner/partner or Director ever been declared bankrupt? Yes No
- If Yes, please provide details
- .....

12. Period of Insurance: From: / / To: / /

13. BUSINESS / PROFESSIONAL ACTIVITIES AND OTHER GENERAL INFORMATION

- a. Provide details of all of your Business Activities and your Profession for those companies noted in Question 1 and any subsidiaries.

	Activity / Profession	Details
<input type="checkbox"/>	In Home Care, Disability Care or Community Care	PLEASE COMPLETE ADDENDUM TWO
<input type="checkbox"/>	Residential Aged Care	PLEASE COMPLETE ADDENDUM ONE
<input type="checkbox"/>	Serviced Apartments or Assisted Living Units	Total number of Apartments or Units: _____
<input type="checkbox"/>	Independent Living Units / Retirement Village Units	PLEASE COMPLETE ADDENDUM ONE
<input type="checkbox"/>	Over 55's Lifestyle Village	Total number of Units:
<input type="checkbox"/>	Real Estate Ownership (Non Residential Care)	Please complete <b>Question 15</b>
<input type="checkbox"/>	Day Care Centre for Non-Residents	Average Number of Attendees: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly

- b. Are you involved in any other Business or Profession apart from those listed above for which you require coverage under this proposed Insurance? Yes No
- If Yes, please provide details:
- .....

- c. Do any of your Care Facilities or Retirement Villages have any of the following facilities:

Gymnasium	Yes	No
If Yes:		
Is it open to the public	Yes	No
If Yes please provide details:		
.....		
Is the equipment checked fortnightly and a logbook kept? (mandatory requirement)	Yes	No
Is the equipment serviced annually by a qualified third party? (mandatory requirement)	Yes	No
Swimming Pool / Hydrotherapy Spa	Yes	No
If Yes:		
Is it open to the public	Yes	No
If Yes please provide details:		
.....		
Is there a lifeguard on duty?	Yes	No
Lawn bowls, tennis courts, golf course	Yes	No
Woodwork or Metalwork Facilities (Men's Shed)	Yes	No
Clubhouse	Yes	No
Are any of these facilities hired out or used by non-residents for any purpose?	Yes	No
If Yes, please provide details:		
.....		

d) Will you be involved in fundraising activities such as Community Fairs, Fetes, Car Boot sales, Farmers Markets, Carols by Candlelight, Dinner Dance, Balls, Walkathons, Fun Runs, Bike Rides or the like?

Yes No

If Yes, please provide details:

.....

14. Indicate by way of percentage to which care sector your services are provided:

Geriatric – 65 years and over	%
Adults with Physical and or Intellectual Disabilities – 18 years and over	%
Youth with Physical and or Intellectual Disabilities – 13 to 17 years	%
Children with Physical and or Intellectual Disabilities – 0 to 12 years	%
Services provided to any person (other than Geriatric) that do not have a Physical and or Intellectual Disability – Please provide details	%

15. Location/s of Office/s occupied by you for the purpose of conducting your Business. Aged care facilities and retirement villages should be noted in addendum.

Address / Location	Owned or Leased	Occupied As
	Owned Leased	
	Owned Leased	
	Owned Leased	
	Owned Leased	
	Owned Leased	

a) Are all buildings in good repair and comply with Council and Fire Brigade regulations? Yes No

If No, please provide details of upgrades required to comply

.....

16. Real Estate Ownership (Non Residential Care)

List Properties owned but not occupied by you or vacant land (if land indicate size)

Address / Location	Land or Building	Occupied as
	Land Building	
	Land Building	
	Land Building	
	Land Building	
	Land Building	

a) Are all buildings in good repair and comply with Council and Fire Brigade regulations? Yes No

If No, provide details of upgrades required to comply

.....

b) Do you ensure that all maintenance and building contractors provide written confirmation that all contractors or sub-contractors of theirs hold Public Liability insurance? Yes No

17. Provide details of the Turnover (Revenue) for all business operations to be insured:

Estimated Turnover (Revenue) next financial year	20__ / 20__	\$
Actual Turnover (Revenue) last financial year	20__ / 20__	\$

For the calculation of Stamp Duty indicate your Revenue in percentage terms split by state as follows:

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Percentage	____%	____%	____%	____%	____%	____%	____%	____%

18. Estimated annual payroll split as follows:

	Total Number of Staff		
	Full-Time	Part-Time	Casual
Principals/Partners			
Office Staff			
Registered Nurses / Enrolled Nurses			
Care Staff			
Allied Health			
Volunteers			
Other Staff: (Please provide details here)			
Total			

TOTAL staff wages for the above	\$
---------------------------------	----

19. Staff

Do you ensure and record that all Nursing Staff, Physiotherapists, Podiatrists, Speech Therapists and the like employed by you or who provide services on your behalf i.e contract staff, are fully qualified, registered and licensed to perform such work as required by applicable legislation? Yes No

20. Contractors and Labour Hire

a) Do you anticipate or do you regularly use contractors or labour hire personnel? Yes No

Nursing or Attendant Care workers providing labour only and under your direct supervision	\$
Nursing or Attendant Care workers providing labour only and not under your direct supervision	\$
Allied Medical Service providers such as Physiotherapists / Podiatrists / Occupational Therapists	\$
General contractors such as Gardeners, Maintenance under your direct supervision	\$
General contractors such as Gardeners, Maintenance not under your direct supervision	\$

b) Do you confirm that all contracted allied medical service providers, nursing and care personnel have their own Malpractice Insurance and Public Liability Insurance? Yes No  
 If No, do you confirm that they are covered by similar insurance policies held by the Employment Agency used to source their services? Yes No

21. Compliance

a) Do you comply with Quality of Care Principal 2014 under Section 96-1 of the Aged Care Act including amendments and/or replacement Legislation? Yes No

<https://www.health.gov.au/health-topics/aged-care/about-aged-care/aged-care-laws-in-australia>

b) Are you currently operating a facility that has failed to meet one or more expected outcomes in the Aged Care Quality Standards? Yes No

If Yes, provide details in the NOTES section of this application including the outcomes failed and corrective action taken by the facility and when you expect to meet all 8 of the standards.

c) Are you compliant with the AICD's governance obligations? Yes No

<https://www.aicd.com.au/regulatory-compliance/royal-commission-updates/aged-care/toolkit-for-governing-the-aged-care-sector.html>

If NO, will you be compliant on or before 01/12/2023? Yes No

**22. Abuse**

- a) Do all employees, contractors and/or volunteers undergo formal interview processes including reference checks, working with children checks, working with vulnerable persons checks, criminal record checks and police checks prior to starting with you? Yes No
- b) Do you have a formal policy in place which addresses the prevention and reporting of abuse including sexual abuse? Yes No  
 If Yes, when was the policy last updated? .....

**PLEASE PROVIDE A COPY OF YOUR MOST RECENTLY UPDATED PREVENTION OF ABUSE POLICY.**

- c) Do you comply with all relevant state child and vulnerable person protection legislation? Yes No
- d) Do all employees, volunteers and contractors engage in an ANNUAL induction and/or training program and are records kept that they have attended in relation to the prevention and reporting of abuse including sexual abuse? Yes No

Please note: This refers to volunteers and contractors who have direct contact with residents/clients

- e) Do you investigate and formally report on any and every suspected case of abuse? Yes No
- f) If, after initial investigation, there are reasonable grounds that sexual abuse or other abuse may have taken place, do you have documented procedures in place which deal with the investigation, suspension of employment or service in the case of an employee, contractor or volunteer? Yes No
- g) After initial investigation, are all suspected, believed on reasonable grounds or actual cases of abuse referred to the appropriate authorities? Yes No
- h) Do you prohibit individuals who have had prior convictions relating to theft, fraud or dishonesty, a sexual offence, abuse or related offences from working for you or doing volunteer work for or on behalf of your Business? Yes No  
 If No, to any of the above, please provide details:  
 .....

- i) Do you administer psychotropic medication or use other forms of restraint? Yes No
- j) Do you check that 'informed consent' has been obtained from the client or their substitute decision maker or in an emergency a Doctor? Yes No  
 If No, please provide details:  
 .....

**ONLY COMPLETE THIS SECTION IF YOU REQUIRE MANAGEMENT LIABILITY INSURANCE IF NO SKIP TO QUESTION 32**

**23. DO YOU REQUIRE MANAGEMENT LIABILITY INSURANCE? Yes No**  
**IF YES, PLEASE PROVIDE A COPY OF YOUR MOST RECENT FINANCIAL ACCOUNTS**

- a) Does the proposed Insured presently carry Management Liability/Directors and Officers Liability Insurance? Yes No
- b) Is the Business (as proposed) solvent and can it meet its debts as and when they fall due? Yes No
- c) Has the proposed Insured issued any prospectus in the last 3 years or publically disclosed an intention to make any public offering of securities within the past year? Yes No
- d) Are the Financial Accounts audited by an independent registered company auditor? Yes No
- e) Has there been any change in the financial position of the business, or any event which has occurred which is not detailed in the annual report submitted with this Application or information of a material nature which could affect the financial position, liability, operation or capital structure of the business? Yes No

- 24. Has the proposed Insured:**
- a) publically announced that it is currently considering acquisitions, tender offers or mergers? Yes No
  - b) been the subject of any attempted takeover bid/offer in the last 3 years or is it aware of any current proposals relating to a takeover bid the business? Yes No
  - c) sold any companies in the last five years? Yes No  
 If YES please provide details:  
 .....

**OPTIONAL SUB-LIMITED COVER FOR MANAGEMENT LIABILITY**

Indicate whether any of the following additional covers are required. An additional premium will be charged.

- 25. Crisis Cover:** Yes No
- 26. Public Relations Expense:** Yes No

**27. Internet Liability:** Yes No

If Yes,

- a) Is a privacy policy posted on all internet sites? Yes No
- b) Does the proposed Insured make available medical and or health information pertaining to identifiable residents or clients? Yes No

If Yes, please provide details:

.....

**28. Statutory Liability:** Yes No

If Yes,

- a) Does the proposed Insured comply with all statutory requirements relating to the Business? Yes No
- b) In the past five years has the proposed Insured or any of its directors or officers ever received a fine or penalty or infringement notice (other than for traffic offences) imposed by a Federal, State, Territory or local government or other regulatory authority? Yes No
- c) In the past five years have there been any incidents or circumstances which could give rise to a fine or penalty (other than for traffic offences) being imposed on the proposed Insured or any of its directors or officers by a Federal, State, Territory or Local Government or other regulatory authority? Yes No

If Yes to (b) and or (c) please provide details:

.....

**29. Tax Audit:** Yes No

If Yes,

- a) Does an independent external accountant prepare the proposed Insured's financial statements? Yes No
- b) Does the proposed Insured perform regular procedural reviews or internal audits? Yes No
- c) Has an Audit by a commissioner of Taxation been conducted? Yes No
- d) Has the proposed Insured been fined or penalised in the last five years? Yes No
- e) Has the proposed Insured been notified of a pending or likely Tax Audit? Yes No
- f) Does the proposed Insured believe or have any reason to suspect that it will be the subject of a Tax Audit? Yes No

If Yes to (c), (d) (e) or (f) please provide details:

.....

**30. Crime:** Yes No

a) What is the maximum amount of cash on the premises at any one time? .....

- b) Are there at least two people required to authorise electronic transfer of funds or sign cheques over \$10,000? Yes No

If No, please provide details:

.....

**31. Employment Practices Liability:** Yes No

- a) Does the proposed Insured currently have Employment Practices Liability Insurance? Yes No

If Yes, how many years have you continuously held Employment Practices Liability Insurance.....years

- b) How many officers and employees have resigned, been terminated (with or without cause) or have retired within the last 12 months?

<b>Officers</b>		<b>Employees</b>	
-----------------	--	------------------	--

- c) Do you have a written human resources manual or equivalent written management guidelines? Yes No
- d) Have there been any closures, consolidations or retrenchments within the previous 24 months or do you anticipate any closures, consolidations or retrenchments within the last 24 months? Yes No

If Yes, please provide details including how many employees will be affected:

.....

- e) Has there been or is there now pending any prosecution or legal action against any of the proposed Insureds including subsidiaries and or any director or officer under the Competition and Consumer Act; Unfair Dismissal or Anti-Discrimination legislation; Work Choices legislation, bullying and harassment laws or any other statute or any action relating to a breach of contract? Yes No

If Yes, please provide details:

.....



**CLAIMS HISTORY**

32. Have any claims / circumstances / losses been made against any proposed Insured under a Policy of Insurance that this Insurance is proposed to replace during the past 5 years? Yes No

This information should also include incidents, accidents, matters or circumstances made or notified to previous insurers over the past 5 years.

If Yes, please provide details:

Date	Claimant	Particulars	Insurer	Total Claim Amount	Excess amount paid	Does the Total Claim Amount include the Excess
GENERAL LIABILITY:						
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
PROFESSIONAL INDEMNITY AND MALPRACTICE LIABILITY:						
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
MANAGEMENT LIABILITY:						
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No
				\$	\$	Yes No

33. Are there any facts, incidents, accidents, matters or circumstances that gave rise or may give rise to a claim of the type to be insured under the Policy of Insurance that this Insurance is proposed to replace during the past 5 years? Yes No

If Yes, please provide details:

Date	Claimant	Particulars	Insurer	Estimate
				\$
				\$
				\$
				\$

**INDICATE THE LIMITS OF LIABILITY REQUIRED BY TICKING THE APPROPRIATE BOX**

<b>POLICY SECTION ONE -</b>			
GENERAL LIABILITY	\$10 Million	\$20 Million	Other - \$

<b>POLICY SECTION TWO -</b>			
PROFESSIONAL INDEMNITY AND MALPRACTICE LIABILITY	\$1 Million	\$2 Million	\$5 Million
	\$10 Million	\$20 Million	

<b>POLICY SECTION THREE -</b>			
MANAGEMENT LIABILITY	\$1 Million	\$2 Million	\$5 Million
	\$10 Million	\$20 Million	

<b>POLICY SECTION THREE – SUBLIMITED COVERS</b>				
EMPLOYMENT PRACTICES LIABILITY	\$500,000	\$1 Million	\$2 Million	\$5 Million
CRISIS COVER	\$50,000	\$100,000		
PUBLIC RELATIONS EXPENSES	\$50,000	\$100,000		
STATUTORY LIABILITY	\$1 Million	\$2 Million		
TAX AUDIT	\$20,000	\$50,000	\$100,000	
INTERNET LIABILITY	\$1 Million			
CRIME	\$50,000	\$100,000	\$150,000	\$250,000
	\$500,000	\$1 Million		

**TO BE COMPLETED BY AN AUTHORISED OFFICER - READ CAREFULLY BEFORE SIGNING**

**DECLARATION**

I/We declare that:

- I am authorised by each of the Applicant(s) to sign this Proposal
- The statements in this Proposal are true and complete and no material information has been withheld
- I have read and understood the Important Notices accompanying this Proposal
- I have diligently made all necessary enquiries in order to comply with the duty of disclosure
- I have read the Pen Underwriting Privacy Statement on this Proposal and consent to the use, disclosure and obtaining of personal information about the insured for the purposes shown in the Privacy Statement
- Where I have provided information about another individual, that individual has been made aware of that fact and of the Pen Underwriting Privacy Statement
- I acknowledge that Pen Underwriting relies on the information and representations in this Proposal and otherwise made by me or on my behalf in relation to this insurance
- Except where indicated to the contrary, I understand that any statement made in this Proposal will be treated as a statement made by all persons to be insured
- I undertake to notify Pen Underwriting of any material alteration to the information contained in this Proposal prior to inception of the proposed insurance
- I understand that no insurance is in place until such time as Pen Underwriting has confirmed acceptance of the proposed insurance

Signature:.....

Date: .....

Full Name:.....

Title: .....

# ADDENDUM

## Instructions

- Answer each question below as directed in the Home and Community Care Providers Application form.
- If there is insufficient space, provide further information in the additional information section.
- All attached documents form part of this Application Form.

### PART ONE – AGED CARE FACILITIES, RETIREMENT VILLAGES

If you own or operate any of the above please complete the table below. In the event there is insufficient room please provide Property Asset Schedule

Property Name	Address	Aged Care Facility / Retirement Village	Total Bed numbers / Dementia Care Beds / Independent Living Units	If Aged Care Facility – Star Rating
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	
		Aged Care Retirement	..... Total Bed Numbers ..... Dementia Beds .....ILU's	

## PART TWO – HOME AND COMMUNITY CARE

Only complete this addendum if you provide this service. We define home and community care as in home care, disability care, community care and/or other care related services away from your premises or if a retirement village operator as an additional service to your residents.

1. Please advise the total number of clients receiving services and turnover derived from these activities.

Total number of clients:	
Turnover:	\$

2. Indicate if you are involved in any of the Activities listed below:

a)	Household tasks ie. Cleaning, shopping, preparation and/or delivery of meals, laundry, gardening, lawn mowing	Yes	No
b)	Personal care ie. assistance with administering medication, showering, dressing, toileting etc	Yes	No
c)	Community support and/or companionship, transportation	Yes	No
d)	At home nursing care or within an Aged Care Facility	Yes	No
e)	NDIS Plan Management, aged care support packages or support co-ordination	Yes	No
f)	Centre based day care for the aged or disabled If Yes, please provide details in NOTES section	Yes	No
g)	Home modification ie. Accessibility Alterations	Yes	No
h)	Exercise and/or massage therapy	Yes	No
i)	Clients requiring medical ventilation, tracheotomy, peg feeding, catheter care, bowel care If Yes, are staff specifically qualified                      Yes              No	Yes	No
j)	Support in finding and retaining employment for people with disability	Yes	No
k)	Sale and/or hire of goods, equipment or aids for people with a disability	Yes	No
l)	Outside school hours care for children with a disability	Yes	No
m)	Registered training (RTO) for carers in the aged care or community care industry	Yes	No
n)	Social Enterprise and/or provision of training for people with disability	Yes	No
o)	On-hire of staff to other providers	Yes	No
p)	Behaviour counselling for children, youth or adults, early childhood intervention support WITHOUT a diagnosed disability	Yes	No
q)	Operation of a psychiatric hospital	Yes	No
r)	Provide care or services within a detention centre or correctional facility	Yes	No
s)	Foster agency or operation of a foster home, out of home care for children or youths	Yes	No
t)	Supervised contact visits and/or handovers of children between parents	Yes	No
u)	Drug and alcohol treatment centre/ Drug and alcohol rehabilitation and/or counselling	Yes	No
v)	Are you knowingly providing ANY services to persons with a known history of physical and/or sexual abuse and/or dangerous behaviour that could result in property damage	Yes	No
w)	Financial intermediary and or financial advice OTHER THAN NDIS administration for clients	Yes	No

3. Accommodation / Respite / Group Homes (IF APPLICABLE)

a)	Permanent accommodation, respite or shared housing for persons with a disability – 18 years of age or over	Yes	No
b)	Permanent accommodation, respite or shared housing for persons with a disability – Under 18 years of age – <u>PLEASE NOTE WE ARE UNABLE TO INSURE RISKS WHICH PROVIDE ACCOMMODATION FOR CHILDREN PERMANENTLY IN CARE</u>	Yes	No

*\*For the purpose of question 3) Permanent Accommodation is defined as a premises including but not limited to a residential property, hotel, serviced apartment, Group Home provided by the Insured where a Client or Resident resides for more than 30 consecutive days.*

