



**Aged Care
Combined Liability
Application Form**
v0120

IMPORTANT NOTICES

Please read these Important Notices before completing this application form.

Your Duty of Disclosure

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

You have this duty until we agree to insure you.

You have the same duty before you renew, extend, vary or reinstate an insurance contract.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If you do not tell us something

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

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

Claims Made Sections

Sections 2 and 3 of the Policy are issued on a claims made and notified basis. This means that Sections 2 and 3 of this 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

Where a Limited Retroactive Date is specified in the Schedule in respect to Section 2, Section 2 of the Policy will not provide cover in relation to acts, errors or omissions committed or alleged to have been committed prior to the Retroactive Date.

Where a limited Retroactive Date is specified in the Schedule in respect to Section 3, Section 3 of the Policy will not provide cover in relation to Wrongful act(s) committed or alleged to have been committed prior to the Retroactive Date.

Other Party's Interests

You must tell us about all parties (e.g. financiers, lessors) to be covered by this insurance. We will protect their interests only if you have told us about them and we have noted them on the Schedule or endorsed their name on the Policy as an interested party.

Privacy

Pen Underwriting and the Insurer(s) 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 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.

Preventing the Insurers Right of Recovery

If you have agreed not to seek compensation from another person who is liable to compensate you for any loss, damage or liability, which is covered by the Policy, the Insurer will not cover you under the Policy for that loss, damage or liability.

Complaints Handling

If you are dissatisfied with a decision Pen Underwriting makes, our service, the service of others we appoint to discuss insurance matters with you, or a claim settlement, we have an internal dispute resolution process to assist you. For further information, ask for a copy of our Complaints and Disputes Resolution Policy or visit www.penunderwriting.com.au.

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IMPORTANT NOTICE

- Please answer all questions in full. Where appropriate, tick the 'Yes' or 'No' box that best indicates your reply.
- If there is insufficient space provided, please 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):

1. Named Insured – Referred to as You or Your throughout this application form.

Please note: The Definition of **Named Insured** in the policy includes the Insured named and any subsidiary company (Including subsidiaries thereof) therefore there is no need to list subsidiaries of the companies listed below. **You are however required to declare all business activities, turnover, and provide other underwriting information for your entire business, including all subsidiaries for which this insurance is proposed.**

(a) Please provide details of the proposed Named Insured to be covered by Policy Section 1 Public & Products Liability including trusts and or trading names if applicable:

.....

(b) Please provide details of the proposed Named Insured to be covered by Policy Section 2 Professional Indemnity / Medical Malpractice. (The Insured's that should be noted under this Policy are those that provide medical or care services and include the Approved Provider.) Please do not list property owners and other investment companies.

.....

(c) Please provide details of the proposed Named Insured to be covered by Policy Section 3 Directors and Officers Liability (This should be the holding company. The latest consolidated financial accounts must be attached with this application.) To qualify for cover the entity must be incorporated such as an Incorporated Association, Company Limited by Guarantee or Proprietary Limited Company. Note that if only Employment Practice Liability is required list only those companies that employ staff.

.....

(d) Are you involved in a Joint Venture or Partnership?. Yes No

If Yes,

(i) Do you want your interests in the Joint Venture or partnership to be included in Policy Section 1 and Policy Section 2 of this proposed Insurance? Yes No

If Yes,

Name of Joint Venture or Partnership	Percentage Interest

Please include the information relating to such Joint venture and or Partnership in all the answers in this application. If the information is not included then there is no coverage under this proposed insurance for such Joint Venture or Partnership.

(e) How long have you been in business:

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(f) Has the Business ever traded under a different name? Yes No

If **Yes**, please provide details:

.....
.....

(g) Has the Business ever been involved in a Merger/Takeover/Acquisition? Yes No

If **Yes**,

Name of Company	Date of Merger Takeover/Acquisition	Did Merger Takeover/Acquisition include the liabilities
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>

(h) Does the Business envisage any changes in ownership? Yes No

If **Yes**, Please provide details:

.....
.....

(i) Please indicate your legal status:

Private Company Public Company Not for Profit Organisation

(j) Are you registered for GST purposes? Yes No

If **Yes**,

Please provide your ABN:

Please provide your Income Tax Credit:

(k) Are your insurance premiums stamp duties exempt? Yes No

If **Yes**, Please ensure the Stamp Duty Exemption form attached to this application form is complete.

2. Period of Insurance: **From:** ____/____/____ **to** ____/____/____

3. BUSINESS / PROFESSIONAL ACTIVITIES:

Please provide full details of your Business Activities and your Profession for those companies noted in Question 1 and any subsidiaries thereof. If more than one, please select all appropriate boxes and if inadequate space to answer questions, please use the additional information section.

In Home Care, Disability Care or Community Care (If selected, please complete Question 4)

Residential Aged Care - *Please indicate number residents at 100% occupancy*

Please advise the number of Dementia Care Beds

Number of beds allocated to Non Geriatric Care such as convalescing care or transitional care

Number of Beds allocated to Non Geriatric residents with physical or mental health disability

Serviced Apartments or Assisted Living Units – *Please indicate number of apartments/units*

Respite care or restorative care - *Please indicate number of beds*

Independent Living Units / Retirement Village units - *Please indicate number of units*

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(c) Please indicate by way of percentage to the care sector services noted in Question 4(a) are provided:

Geriatric or Elderly	%
Youth with Physically and or Intellectual Disabilities	%
Adults with Physically and or Intellectual Disabilities	%
Other:	%

5. Please advise total number of clients receiving services and turnover derived from the activities listed in Question 4(a):

Total Number of Clients:

Turnover: \$

6. Please provide details of the total Turnover for **all** Business Activities noted in Questions 3 & 4:

Estimated Turnover (Revenue) current financial year	\$
Actual Turnover (Revenue) during last financial year	\$
Actual Turnover during the previous financial year	\$

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

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Percentage								

7. (a) If you have indicated in Question 3 or 4 that you provide any of the following care services: Residential Aged Care; Transitional Care; Short Term Respite or Restorative Care; Home Care packages; Services under the Commonwealth Home Support program or National Aboriginal and Torres Strait Islander flexible Care Program or in-home care, **Then**, are you familiar with and do you comply with the 8 standards set out in the Aged Care Quality Standards issued by the Aged Care Quality and Safety Commission which apply from 1 July 2019. Yes No

If you answered No, please advise which of the 8 standards you are not familiar with or at this time do not comply with, including how you will achieve compliance and in what time frame compliance will be achieved.

.....

(b) If you have indicated in Question 3 or 4 that you provide services to persons with disabilities or mental health, are you familiar with and do you comply with the 6 National Standards that apply under the Australian Health Service Safety and Quality Accreditation Scheme (second edition effective January 2019) issued by the Australian Commission on Safety and Quality in Health Care being:

- Rights Yes No
- Participation and Inclusion Yes No
- Individual outcomes Yes No
- Feedback and Complaints Yes No
- Service Access Yes No
- Service Management Yes No

If you answered No, to any of the above standards, please provide detail in the additional information section of this application to explain how you are going to achieve compliance and in what timeframe compliance will be achieved.

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8. 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**, please provide details in the additional information 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.

9. Do each of your clients have a documented and signed Care Plan detailing services agreed? Yes No

10. Are you involved in any other Business or Profession apart from those listed in Q3 and Q4 for which you require coverage under this Proposed Insurance? Yes No

If **Yes**, please provide details:

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.....

11. Estimated Annual Payroll Split as follows:

	Number of Staff	Wages
Principals/Partners		\$
Office Staff		\$
Registered Nurses / Enrolled Nurses/ Attendant Carers		\$
Food & Domestic Services Staff		\$
Physiotherapists / Podiatrists / Occupational Therapists		\$
Other:		\$
Total		\$

12. Do you anticipate using or do you regularly use contractors or labour hire personnel? Yes No

If **Yes**, please provide estimated annual contract value for:

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, Kitchen under your direct supervision	\$
General contractors such as Gardeners, Maintenance, Kitchen not under your direct supervision	\$

13. Do you operate a service company that hires staff and then on-hires them or places them in companies within the group of companies owned and or operated by you? Yes No

If **Yes**, please provide the name of the service company.....

14. In states where permitted, does the Insured include contractors and sub-contractors within their workers compensation insurance program? Yes No

15. Do you confirm that:

(a) All contracted allied medical service providers, nursing and care personnel have their own Malpractice Insurance and General Liability Insurance? N/A Yes No

If **No**,

(i) Do you confirm they are covered by similar insurance policies held by the Employment Agency used to source their services? N/A Yes No

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16. Do you record and ensure 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? N/A Yes No

17. Do you offer child minding arrangements for staff working in your business? Yes No

If **Yes**, please advise the number of children at any one time:

18. Location(s) of Premises **occupied** for the purpose of conducting the Insured's Business. (if inadequate space please provide separate listing)

Address / Location	Owned or Leased	Purpose Built
	Owned <input type="checkbox"/> Leased <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Owned <input type="checkbox"/> Leased <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Owned <input type="checkbox"/> Leased <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

19. Please list Properties owned but not occupied by the Insured (if land please indicate size)

Address / Location	Land or Building	Occupied as
	Land <input type="checkbox"/> Building <input type="checkbox"/>	
	Land <input type="checkbox"/> Building <input type="checkbox"/>	
	Land <input type="checkbox"/> Building <input type="checkbox"/>	

20. Are all the buildings noted in Questions 18 and 19 in good repair and comply with Local Council and Fire Brigade Regulations? Yes No

If **No**, please provide details of upgrades required:
.....

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

- (a) Swimming Pool / Hydrotherapy Spa Yes No
 - (b) Lawn Bowls, Tennis Courts, Golf Courses Yes No
 - (c) Woodwork or Metalworking facilities (men's shed) Yes No
 - (d) Club House Yes No
- If **Yes** to (a)-(c), are any of these facilities hired out or used by non-residents for any purpose? Yes No

22. 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 detail:
.....

23. Will you be undertaking any demolition, construction, renovation and or development activity during the next 12 months? Yes No

- If **Yes**,
- (a) Estimated total aggregate contract value of any projects over \$500,000:
 - (b) Please provide details of all contracts:
.....
 - (c) Has the insured obtained or will the Insured obtain written confirmation that all contractors and or sub-contractors hold separate public liability insurance noting the Insured's interest as principal? Yes No

If **Yes**, has or does the Insured confirm coverage includes injury to any other contractor who may be on the same site? Yes No

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24. Do you assume liability under contract or hold harmless agreement or assume a duty or obligation by way of contract, warranty, guarantee which exceed the Insured's liability in the absence of such contract warranty or guarantee? Yes No

25.

(a) Do all employees, contractors and 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 for you? Yes No

(b) Do you have a formal policy in place which deals with the prevention of abuse including sexual abuse? Yes No

If 'Yes', when were the policies and procedures last updated? ____/____/____

(c) Do all employees, all volunteers and all contractors attend and sign off on the fact that they have attended an induction and training program Yes No

(d) Do you comply with all relevant state child and vulnerable person protection legislation? Yes No

(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 a contractor or volunteer? Yes No

(g) 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:

.....
.....

(h) Do you administer antipsychotics or use other forms of restraint? Yes No

(i) Do you have clients / residents on antipsychotics for longer than a 12 week duration? Yes No

If Yes, to either (h) or (i) please provide details:

.....
.....

26. Do you presently carry Malpractice Liability and or Professional Indemnity Insurance? Yes No

27. Do you require Directors and Officers Liability Insurance? Yes No

If Yes,

(a) Do you presently carry 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) Have you 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

If Yes,

How often:

Name of Audit Firm:

(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

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28. Have you
- (a) publically announced that you are 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 are you aware of any current proposals relating to a takeover bid for your business? Yes No
 - (c) sold any companies in the last five years? Yes No

If **Yes**, please provide details:

.....
.....

29. Has the proposed Insured issued any prospectus in the last 3 years or publically disclosed its intention to make a public offering of securities? Yes No

If **Yes**, please provide details:

.....
.....
.....

30. Has there been or is there now pending any prosecution of the proposed Insured including subsidiaries under the Corporations Act, Trade Practices (Fair Trading) Act, Occupational Health and Safety Act or any other statute? Yes No

If **Yes**, please provide details:

.....
.....

31. Has any director or executive officer of the Proposed Insured:
- (a) ever been declared bankrupt? Yes No
 - (b) been a director or executive of an organisation placed in administration, receivership, liquidation or provisional liquidation? Yes No

If **Yes**, Please provide details:

.....
.....
.....

Optional Extensions for Directors and Officer Liability

32. Please indicate whether any of the following additional covers are required. An additional premium will be charged.
- (a) **Public Relations Expenses:** Yes No
 - (b) **Internet Liability:** Yes No
- If **Yes**,
- (i) Do you have a privacy policy posted on all internet sites? Yes No
 - (ii) Do you make available medical and or health information pertaining to identifiable residents or clients? Yes No

If **Yes**, please provide details:

.....
.....
.....

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(c) **Statutory Penalties:** Yes No

If **Yes**,

(i) Do you comply with all statutory requirements relating to your Business? Yes No

(ii) In the past five years has the Company or a director or officer of the Company 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

(iii) 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 Company or a director or officer of the Company by a Federal, State, Territory or Local Government or other regulatory authority? Yes No

If yes to (ii) and or (iii) please provide details:

.....

(d) **Tax Audit:** Yes No

If **Yes**,

(i) Does an independent external accountant prepare the company's financial statements? Yes No

(ii) Does the Insured perform regular procedural reviews or internal audits? Yes No

(iii) Has an Audit by a commissioner of Taxation been conducted? Yes No

(iv) Has the corporation been fined or penalised by the ATO in the last five years? Yes No

(v) Has the Company been notified of a pending or likely Tax Audit? Yes No

(vi) Do you believe or have any reason to suspect you or the company will be the subject of a Tax Audit? Yes No

If **Yes** to (iii), (iv) (v) or (vi) please provide details:

.....

ONLY COMPLETE THIS SECTION IF YOU REQUIRE CRIME INSURANCE

33. Is the handling of cheques or cash limited to Principals and Accounts staff? Yes No

If **Yes**, how many Principals and staff are authorised to handle cheques and or cash?

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

35. Are the financial accounts audited by an independent registered company auditor? Yes No

36. Are there at least two people required to authorise or countersign cheques? Yes No

37. Are there at least two people required to authorise Electronic Transfer of Funds? Yes No

38. Is there separation of duties between persons handling money, including EFT? Yes No

39. Is there a delegation of authority regarding the limit an employee can authorise payments? Yes No

40. How often and by whom are entries in the cashbook checked with vouchers, reconciled bank statements and returned cheques?

Responsible Persons	Reconciliation Cycle

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ONLY COMPLETE THIS SECTION IF YOU REQUIRE EMPLOYMENT PRACTICES LIABILITY INSURANCE

41. Do you currently carry Employment Practices Liability Insurance? Yes No
 If **Yes**, how many years have you continuously held Employment Practices Liability Insurance years

42. Advise the number of employees and workers engaged by the Business over the past three years:

	Current Year	Last Year	Previous Year to Last Year
Full-Time Employees			
Part-Time Employees			
Temporary Workers / Contract Workers			

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

Officers	
Employees	

44. Do you have a written human resources manual or equivalent written management guideline? Yes No

45. 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:

.....

46. 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 Trade Practices 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

47. Have any claims been made against any Proposed Insured under a Public and Products Liability policy, Malpractice / Professional Indemnity Liability Policy, Crime insurance, Directors & Officers Policy or Employment Practices Liability Policy or any optional extension in this Application during the past 5 years? Yes No

This information should also include claims made or notified to previous insurers over the past 5 years.

If **Yes**, please provide details:

Date	Claimant	Particulars	Insurer	Value of Claim
				\$
				\$
				\$
				\$
				\$

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48. 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 proposed Public and Products Liability Policy Section, Malpractice / Professional Indemnity Liability Policy Section or the Directors and Officers Policy Section (incl. Employment Practices Liability and Crime insurance) or any optional extension requested other than those already declared to the Insurer. Yes No
If any, please provide details

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

49. Only answer this question if you are **not currently insured with Pen.**

Please provide the number of incidents that you have reported to previous insurers over the last 3 years

Class of Insurance	Total Number of incidents reported in last 3 years
General Liability	
Professional Indemnity	
Directors & Officers (incl. Employment Practices)	

PLEASE INDICATE THE LIMITS OF LIABILITY REQUIRED BY TICKING THE APPROPRIATE BOX:

Section 1 - Public & Products Liability \$5 million \$10 million \$20 million Other, Specify \$ _____

Section 2 - Malpractice Liability \$2 million \$5 million \$10 million Other, Specify \$ _____

Section 3 - Directors & Officers Liability \$2 million \$5 million \$10 million Other, Specify \$ _____

If Option taken: Public Relation Expenses

Public Relation Expenses \$50,000 \$100,000

Statutory Penalties \$1 million

Tax Audit \$20,000 \$50,000 \$100,000

Internet Liability \$1 million

Crime \$100,000 \$150,000 \$250,000

Section 3 - Employment Practices Liability \$1 million \$2 million \$5 million

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DECLARATION

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

I/We declare that:

- I/We have never had an Insurer decline an Application, impose special terms or exclusions, decline to renew My/Our insurance or cancel an insurance policy held by Me/Us.
- I/We have read and understood the Important Notices on this Application.
- I/We am authorised by each of the Applicant(s) to sign this Application.
- The statements in this Application are true and complete and no material information has been withheld.
- I/We have diligently made all necessary enquiries in order to comply with the duty of disclosure.
- I/We have read the Pen Underwriting Privacy Statement on this Application and consent to the use, disclosure and obtaining of personal information about the insured for the purposes shown in the Privacy Statement.
- Where I/We have provided information about another individual, that individual has been made aware of that fact and of the Pen Underwriting Privacy Statement.
- I/We acknowledge that Pen Underwriting relies on the information and representations in this Application and otherwise made by me or on my behalf or by our insurance broker in relation to this insurance.
- Except where indicated to the contrary, I/We understand that any statement made in this Application will be treated as a statement made by all persons to be insured.
- I/We undertake to notify Pen Underwriting of any material alteration to the information contained in this Application prior to inception of the proposed insurance.
- I/We understand that no insurance is in place until such time as Pen Underwriting has confirmed acceptance of the proposed insurance.

Signature/s: **Date:**.....

Name/s: **Title:**.....

