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Australis CARE is a division of **Australis GROUP (UNDERWRITING) Pty Ltd**
Australis Group (Underwriting) Pty Ltd ABN 80 082 459 372 AFSL 238170
PO Box 79 Balwyn Vic 3103 www.ausuw.com

AGED CARE PROVIDERS COMBINED LIABILITY INSURANCE RENEWAL APPLICATION FORM

POLICY 1 - General & Products Liability;
POLICY 2 - Professional Indemnity and Malpractice Liability (incl.) Fidelity Guarantee Extension;
POLICY 3 - Directors and Officers Liability (incl.) Employment Practice Liability Extension.

IMPORTANT NOTICE: PLEASE READ & RETAIN IN YOUR FILE

This is a generic form, not all of the above policies may be included in your current coverage and please note only the policy / (ies) currently insured form part of this renewal.

If you require information about any policy not insured under your current Aged Care Providers Combined Liability Program please seek advise from your Broker. A different application may be required

Renewal of your Aged Care Providers Combined Liability Insurance Policy will be based on information provided in your previous applications together with any change to that information notified in this renewal application so if you are unsure about any aspect of the information previously provided please refer back to the application(s) previously provided.

For the purpose of this application the term **you** / **your** / **Insured** means the Insured as defined in:
Paragraphs 1.5 of Policy 1; and /or 7.6 of Policy 2; and/or 7.5 of Policy 3.

For the purpose of this application the term **we** / **our / us** means Australis Care and /or Australis Group (Underwriting) Pty Ltd and / or the Insurer.

Policies 2 and 3 are issued on a Claim Made Basis:

This means that these sections of the policy respond to: -

1. Claims first made against the Insured during the Period of Insurance and notified to the Insurer during that Period of Insurance, provided that the Insured was not aware prior to the policy inception of circumstances which would have put a reasonable person on notice that a Claim may be made against the Insured, and
2. If during the currency of the policy, the Insured becomes aware of any occurrence which may give rise to a Claim under the policy and during the Period of Insurance gives written notice to the Insurer of such occurrence, any Claim which may be subsequently made arising out of the occurrence of which notification has been given shall be deemed to be a Claim made during the period of this policy whenever such Claim may be made.

When the policy expires, no new claims can be made on the policy even though the event giving rise to the Claim may have occurred during the Period of Insurance.

No indemnity will be provided under this policy in respect of any Claim arising out of circumstances of which the Insured was aware at any time prior to inception and which would have put a reasonable person on notice that a Claim may be made.

Your Duty of Disclosure

Before entering into a contract of general insurance you have a duty under the *Insurance Contracts Act*, to disclose to the Insurer every matter that you know, or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk of the insurance and if so, on what terms. You have the same duty to disclose matters to the Insurer before you renew, extend, vary or reinstate a contract of general insurance.

Your duty however does not require disclosure of matters:

- that diminish the risk to be undertaken by the Insurer;
- that is common knowledge;
- that your Insurer knows or in the ordinary course of their business ought to know; or
- as to which compliance with your duty is waived by the Insurer.

You should note your duty continues after the application form has been completed until the policy is entered into, that is until the date the insurer receives instruction to bind cover.

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Non–disclosure

If you fail to comply with your duty of disclosure, the Insurer may be entitled to reduce their liability in respect of a claim or may cancel the contract. If your non-disclosure is fraudulent, the Insurer may also have the option of avoiding the contract from the beginning. It is therefore vital that you enquire of all entities comprising the insured, including senior staff, before completing the application form and before you sign any declaration confirming the accuracy of in the information disclosed

Surrender or Waiver of Any Right of Contribution or Indemnity

Where another person or company would be liable to compensate the insured or hold the Insured harmless for part or all of any Loss or damage covered by the policy, but the Insured has agreed with that person or company either before or after the inception of the policy that recovery of any Loss or damage from that person or company would not be sought, the Insured will not be covered under this policy for any such Loss or damage.

Contracts by Insured Affecting Rights to Subrogation

If the proposed contract of insurance includes a provision which excludes or limits the Insurer's liability in respect of any loss because the Insured is a party to an agreement which excludes or limits rights to recover damages from a third party in respect of that Loss, signature of any such agreement may place the indemnity under the proposed contract of insurance at risk.

Continuity of Coverage

With respect to any Claims Made Policy (ies) for which you are seeking renewal the policy offers continuity of coverage that means the Insurer shall, notwithstanding the exclusion in respect of prior or pending claims or actions made against you or circumstances or facts known by you which have the potential to give rise to a claim the policy/ (ies) may still respond.

Special terms and conditions apply and these can be found in the respective policy wording.

Retroactive Coverage

With respect to any Claims Made Policy (ies) for which you are seeking renewal the policy has a retroactive date.

Where a date is noted in the schedule then the policy does not cover any claim arising from an actual or alleged act, error, omission or conduct occurring prior to such retroactive date.

PRIVACY POLICY

At Australis GROUP (UNDERWRITING) Pty Ltd, we and the Insurer are committed to protecting your privacy in accordance with the Privacy Act, 1998 (Cth). This Privacy Policy describes our / the Insurers' current policies and practices in relation to the handling and use of Personal Information.

To view our privacy policy please refer to www.ausuw.com

INSURED AND POLICY LIMITS

Facility Name: ____

Your Current Policy Number is: ____

Please indicate that you are either satisfied with the Limit(s) of Liability that you currently enjoy under your current **Aged Care Providers Combined Liability Insurance** program or indicate the limit(s) that you would like us to provide renewal terms on

I am satisfied with the current limits of liability under this policy o Yes o No

If you have indicated **NO** please tick the Limits that you would like Australis CARE to quote for your consideration:-

Policy 1 - Public & Products Liability:	o $5 million	o $10 million	o $20 million	o Other, Specify $____________
Policy 2 - Medical Malpractice Liability:	o $2 million	o $5 million	o $10 million	o Other, Specify $____________
Policy 2 - Fidelity Guarantee:	o $10,000	o $ 20,000	o $50,000	o Other, Specify $____________
Policy 3 - Directors & Officers Liability:	o $2 million	o $5 million	o $10 million	o Other, Specify $____________
Policy 3 - Employment Practices Liability:	o $500,000	o $1 million	o $2 million	

OPTIONAL EXTENSIONS UNDER POLICY 3 DIRECTORS AND OFFICERS LIABILITY:
If you currently have cover under policy 3 please indicate whether any of the following additional covers are required

- Outside Directorships (other then Not for profit) Yes o No o
- Outside Directorships Run Off Cover Yes o No o
- Corporate Crises Cover Yes o No o
- Solvency protection Yes o No o
- Aggregate Limit of Indemnity Yes o No o

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ADDITIONAL INFORMATION

Inadequate Space to Answer

If there is inadequate space to answer our questions on this application form, please use the additional information section provided to answer the questions. Please also attach any brochures, promotional pamphlets or other publications relevant to this application for insurance.

1. Please provide details of the proposed Insured to be covered by Policy 1 General and Products Liability

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____

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Please provide details of the proposed Insured to be covered by Policy 2 Professional Indemnity / Medical Malpractice, the Insured's noted under this Policy are those that provide medical or care services ***(if any other professional services apart from those listed in 7a are to be covered under this proposed insurance they must be noted in 7c)***

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Please provide details of the proposed Entity to be covered by Policy 3 Directors and Officers, 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 a, Proprietary Limited Company.***

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2 Please provide full details in respect of your current Business Activities &/or current Insured's Profession for all Insured's to be insured under this proposed insurance If more than one, please tick all appropriate boxes:

- Home & Community Care o (If you tick this box, please complete Questions 3 & 4)
- Hostel (Low Care) o
- Nursing Home (High Care) o
- Serviced Apartments o
- Respite Services o
- Independent Living Units o
- Retirement Village o
- Real Property Ownership o (Please list properties purchased in the last 12 months in Question 8)
- Day Care Centre for non Residents o
- Kitchen Services for Non residents o
- Laundry Services for non residents o
- Consultants o (Please provide details in the additional information sheet)
- § Management of someone else's Aged Care Facility o
- § Other o (If you tick this box, you must complete questions 3a)

If you operate a Nursing Home or Hostel are you involved in the care of non Geriatric residents / patients in your facility such as patients convalescing after a stay in hospital or those with long term/short term care needs Yes o No o N/A o

If yes, please provide details:

____

ONLY COMPLETE QUESTIONS 3 and 4 IF YOU HAVE TICKED HOME & COMMUNITY CARE or 3a for OTHER

3 Please indicate if you are involved in any of the Activities listed below by ticking the box and indicate the number of individual clients receiving the particular service.

- Domestic Assistance o Number of Clients _____
- Personal Care o Number of Clients _____
- Home Modification or Maintenance o Number of Clients _____
- Assessment of clients for eligibility to access HACC services o Number of Clients _____
- Meals & other Food Services o Number of Clients _____
- In Home Nursing Care o Number of Clients _____
- In Home Respite Care (not at your premises) o Number of Clients _____
- Services such as Physiotherapy, Podiatry or Occupational Therapy o Number of Clients _____
- Care other than Geriatric Care (i.e. adults or youth) o Number of Clients _____
- Broker / Funder of Aged Care Packages or the like o Number of Packages ___

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3a **If you indicated 'other' in questions 2 and require cover under this application (proposed insurance) please provide details for the insurers' consideration.**

4. Please indicate total number of Clients receiving services noted in 3 & 3a Number of Clients _______________

Please indicate the Turnover (Revenue) derived from all activities listed in Question 3 & 3a Turnover$ _______________

5 Please provide details of the Turnover (Revenue) for **all** Business Activities / Profession noted in question 2 & 3 / 3a above.

§ Estimated Turnover (Revenue) current financial year $______________

§ Actual Turnover (Revenue) during the last financial year $______________

§ Actual Turnover (Revenue) during the previous financial year $______________

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

STATE	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
PERCENTAGE								

6. Estimated annual payroll split as follows:

- Principals/Partners No _____ Wages $ ______________
- Office Staff No of staff _____ Wages $ ______________
- Registered Nurses / Enrolled Nurses No of staff _____ Wages $ ______________
- Attendant Carers / Personal Care Attendants No of staff _____ Wages $ ______________
- Food & Domestic Services Staff and the like. No of staff _____ Wages $ ______________
- Physiotherapists / Podiatrists / Occupational Therapists No of staff _____ Wages $ ______________
- Other – List Type_______________________ No of staff _____ Wages $ ______________

Total **Total $**

Do you anticipate or do you regularly use contractors or labour hire? Yes o No o

If 'yes', please provide contract value: $____

Do you ensure that, and record that all contracted personnel, have their own Malpractice Insurance / Professional Indemnity Insurance and General Liability Insurance or that they are covered by the Employment Agency used to source their services. Yes o No o N/A o

7. **Please tick the box if no change in beds or unit numbers from those declared last year o**
Otherwise please advise the <u>current number</u> of beds or units split as follows:

Low Care	High Care	Independent Living	Retirement Village	Serviced Apartments	Respite Care

8 Please list any additional locations/premises including land holdings. (if land holding please indicate size)

Address / Location	Occupied by Insured	Owned or Leased	Purpose Built
	Yes o No o	Owned o / Leased o	Yes o No o
	Yes o No o	Owned o / Leased o	Yes o No o

9. Please confirm that all facilities to be insured under this policy comply with The Aged Care Standards & Accreditation Agency or the Department of Human Services Guidelines Yes o No o N/A o

Are there currently any outstanding requisitions in respect to your accreditation? Yes o No o N/A o

10 Are you undertaking any Development / Construction / Renovation activity during the next twelve months? Yes o No o

If '**yes**', please provide Contract Value and Duration of the project together with the additional bed numbers/unit numbers, that the project will generate.

Contract Value $___________ / Duration _________months / Additional beds/units ___________

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ONLY ANSWER QESTIONS 12 IF YOU ARE RENEWING YOUR FIDELITY GUARANTEE EXTENSION UNDER POLICY 2

11a. Are all controls as provided in answers in your previous application form (s) under the heading Fidelity Guarantee Insurance Extension still in place. Yes o No o

11b What is the maximum amount of cash on the premises at any one time $____

ONLY ANSWER QESTIONS 13 & 14 IF YOU ARE RENEWING YOUR DIRECTORS & OFFICERS LIABILITY INSURANCE

12. Does the Business envisage that any changes in ownership or operation may take place during the forthcoming insurance period? Yes o No o
If 'yes', please provide details:

13. Is the Residents Association an Incorporated Body? Yes o No o

Please provide the Name of the Association ____

14. Is the Entity noted in Question 1 solvent and can it meet its debts as and when they fall due Yes o No o
If 'no', please provide details:

____

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ONLY ANSWER QUESTION 15 IF YOU ARE RENEWING YOUR EMPLOYMENT PRACTICES LIABILITY EXTENSION UNDER POLICY 3

15. Please list the number of employees and workers of the Insured Entity for the past 3 years.

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

CLAIMS HISTORY

16. Are any of the Principals, Partners or Directors aware (after enquiry of all staff, managers and contractors) of any facts, incidents, accidents or circumstances that may give rise to a claim of the type to be Insured under the proposed Public and Products Liability Insurance Policy; Medical Malpractice / Professional / Indemnity Liability Insurance Policy (inc. Fidelity) or the Directors and Officers Liability Insurance Policy (incl. Employment Practices Liability) Yes o No o
If 'yes', please provide details:

Name of Claimant	**Particulars**	**Date of Claim**	**Estimated Quantum**
			$
			$
			$

DECLARATION AND SIGNATURE:

For and on behalf of the Proposed Insured

I hereby declare that I have read the **important notice** on page one and declare that statements and particulars in this application are true and that I have not mis-stated or suppressed any material facts. I agree that this application form together with any other information supplied shall form the basis of any Contract of Insurance entered into. I undertake to inform the insurer of any material alteration to these facts whether occurring before or after completion of this Contract of Insurance.

Signature of Partner, Principal or Director:	Date:
X	

PLEASE SIGN AND DATE THIS DECLARATION ON THE DAY THE DECLARATION IS MADE.
Signature of this form does not bind the applicant or the Insurer to complete the Insurance.

ADDITIONAL INFORMATION

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If there is inadequate space to answer our questions on this Renewal Application Form, please use this Additional Information section to answer the questions. Please also attach any brochures, promotional pamphlets or other publications relevant to this application for insurance. **This information forms part of the application and is subject to the declaration on page 5.**