

Disability Care Comprehensive Insurance Proposal Form

Please select the Sections of cover you require:

Part A: General Liability

General Public and Products Liability Section

Yes No

Part B: Professional Indemnity

Professional Indemnity Section

Yes No

Part C: Personal Accident

Personal Accident Section

Yes No

Policyholder details

This section must be completed.

Name of organisation to be insured (include any subsidiaries)

Trading Name (s) past and present (if applicable)

ABN / ACN / ARBN:

Date organisation first commenced operations:

Authorised contact person

Position

Postal address

Suburb

State

Postcode

Phone

Mobile

Email

Website

Do you have a current stamp duty exemption for general insurance?

Yes No

If yes, which State(s) or Territory does it apply for?

Exemption certificate date

A copy of your exemption certificate must be provided with this proposal form, otherwise Stamp Duty will be applied to your premium.

Are you registered for GST?

Yes No

If yes, what is your ITC percentage?

Disability Care Comprehensive Insurance Proposal Form

Period of insurance

This section must be completed.

Required period of insurance

Commencement date

Expiry date

Information about your organisation

Organisational structure

How is your organisation structured?

- Company limited by guarantee Cooperative / Mutual Incorporated association Partnership
 Private company Privately held company Public company (ASX listed) Public company (not listed)
 Unincorporated association
 Other (please specify)

The following questions must be completed if any Section(s) from Part B: General Liability and / or Part C: Organisation Liability are required.

Is your organisation a subsidiary of another entity? Yes No

If yes, please provide the name of the ultimate holding organisation, its country of incorporation and its website:

Name of subsidiaries and controlled entities required to be insured (if any):

Please provide details of any companies or businesses acquired or disposed of by the business entity or any mergers, consolidation or staff reduction during the last twelve months or any such proposed changes over the next twelve months:

Activities

This section must be completed.

Please provide a full description of the business activities of all entities to be insured by this policy, including details of any advice given and / or services provided:

Has there been any change in the nature of your business activities and those of your subsidiaries in the last 3 years? Yes No

If yes, please provide details:

Disability Care Comprehensive Insurance Proposal Form

Do you anticipate any major change in the nature of your business activities and those of your subsidiaries in the next 12 months? Yes No

If yes, please provide details:

Locations

This section must be completed.

Please advise the locations from which you operate:

Address	Postcode	State
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; width: 50px; height: 20px;"></div>	<div style="border: 1px solid black; width: 50px; height: 20px;"></div>

Owned by you? Yes No

Occupied by you? Yes No

Risk management

This section only needs to be completed if any Section(s) from Part A: General Liability and / or Part B: Professional Indemnity are required.

Are you required to be licensed, registered or accredited? Yes No

If yes, do you have such licence, registration or accreditation? Yes No

Expiry date

Is there any matter currently pending which may impact on your licence, registration or accreditation, or cause them to be suspended or withdrawn? Yes No

If yes, please provide details:

Do you follow a documented risk management system which includes regular analysis, evaluation and prevention of risks associated with your business including the use of incident report procedures? We may request evidence of your risk management policy. Yes No

Is management actively involved in the risk management of your organisation? Yes No

Do you have an audit or compliance committee in place? Yes No

Do you have an OH&S or WorkSafe committee in place? Yes No

Do you ensure all Government regulations are closely abided with and have a dedicated person to implement and monitor? Yes No

Are all your premises, plant and machinery in good repair and are all statutory requirements complied with? Yes No

Are there proper policies in place for the screening of all new employees and / or volunteers? Yes No

If no to any of the above, please provide full details:

Disability Care Comprehensive Insurance Proposal Form

If you engage any subcontractors/contractors/labour hire personnel to perform business-related activities on your behalf: Yes No

What is the estimated annual payment to subcontractors / contractors / labour hire personnel?

Do you ensure all subcontractors / contractors / labour hire personnel have their own Public Liability insurance? Yes No

People

This section only needs to be completed if any Section(s) from Part A: General Liability

Number of employees / other persons engaged in the organisation in Australia	This year	Last year
Directors / Partners / Supervisory / Management:		
Full-time employees (administration only):		
Full-time employees (some manual work):		
Part-time / Casual employees:		
Contract workers / temporary employees:		
Volunteers (max. any one time):		
Estimated total number of patients:		

Financials

This section only needs to be completed if any Section(s) from Part A: General Liability

Please provide a copy of your latest 2 annual reports, financial accounts, rules and procedures, codes of conduct or other documentation which may assist us to gain a complete appreciation of the nature of your organisation.

If your organisation is commencing operations now, please provide a copy of your budgeted financials.

Particulars	Last Financial Year	Previous Financial Year
Current assets:		
Current liabilities:		
Total assets:		
Total liabilities:		
Intangibles:		
Total income/turnover (including grants, subsidies, fees):		
Net profit (loss) after tax:		

Estimated total income/turnover (including grants, subsidies, fees, donations) for the next 12 months

Turnover % split per state

ACT %	NSW %	VIC %	QLD %	SA %	WA %	TAS%	NT %	Overseas %

For any overseas turnover please advise countries:



Disability Care Comprehensive Insurance Proposal Form

History

Previous Insurance

This section must be completed.

The questions relate to all Sections of cover being requested under this proposal for insurance.

Are you currently insured? Yes No

If yes, name of previous insurer(s)

Expiry date

Have you ever had any insurance declined or cancelled, application rejected, renewal refused, claim rejected, special conditions or excess imposed by any insurer? Yes No

If yes, please provide details:

During the last five years, have you claimed under a policy of insurance that this insurance is proposed to replace? Yes No

If yes, please provide details:

Is there now any claim pending or are you aware of any circumstances that may give rise to a claim against you or any other director or officer of the entity applying for this insurance? Yes No

If yes, please provide details:

Insurer	Date of incident	Description of loss/circumstances	Amount paid/outstanding

Organisation History

This section must be completed.

The following questions relate to all Sections of cover being requested under this proposal for insurance.

Has your organisation or any of its directors / officers / executive managers / trustees:

(a) ever been convicted of a criminal offence? Yes No

(b) ever been declared bankrupt? Yes No

(c) ever become insolvent or placed into liquidation or receivership? Yes No

Disability Care Comprehensive Insurance Proposal Form

The following questions must be completed if any Section(s) of Part B: Professional Indemnity are required. These questions apply to you or any of your directors, officers and other persons applying to be insured.

- Has your organisation, you or any director / officer / executive manager / trustee in your business:
- (a) ever had a disciplinary proceeding against you? Yes No
 - (b) ever been the subject of a sanction in your profession, trade or business (not being a conviction or fine for a traffic offence)? Yes No
 - (c) had any complaint or disciplinary proceeding or other inquiry made in relation to your professional conduct? Yes No
- Are you aware of any fact, event or circumstance which:
- (a) might reasonably be expected to lead to civil or criminal proceedings being instituted against your organisation, any director, officer, manager, trustee or employee? Yes No
 - (b) might require you or any of these persons to attend an official investigation, inquiry or other proceedings? Yes No
 - (c) could possibly or validly result in a claim under this proposed insurance? Yes No
 - (d) would have resulted in a claim under this proposed insurance which was not insured?
- Have you or any of the persons applying to be insured been the subject of any complaint or received notice of an enquiry by any State, Territory or Federal regulatory body or other body to which you are accredited in the last three years? Yes No

If yes to any of the above, please provide summary details below and attach full details including the name of the claimant, the outcome of any claim, the total amount paid in judgement or settlement, and claims defence and other settlement costs.

Date	Amount	Details of loss or damage



Disability Care Comprehensive Insurance Proposal Form

Part A: General Liability

Only complete this section if Part A: General Liability is required.

Activities

If you organise any high risk activities, such as abseiling, archery, horse riding, surfing, trail / motor bikes, water sports with power boats:

Are they run by appropriately qualified, accredited and insured third parties?

Yes No

If no, do you have appropriately qualified and accredited employees who are running these activities?

Yes No

Excluded High Risk Activities include:

motor races, motor rallies, motor speed tests, canyoning, caving, rifle/firearms, shooting, aircraft, hang gliding, parachuting, paragliding, white water canoeing/kayaking/rafting (above class 2 rapids), scuba diving, dune buggies, vertical and horizontal bungee jumping, hot air ballooning, gladiator games, unsupported rock climbing, go karts, motocross, martial arts or boxing activities.

Do you provide any of these activities?

Yes No

Underwriting consideration may be given in special circumstances. Cover is not in place until agreed by us in writing.

Over the next twelve months, do you intend to organise any events, exhibitions or festivals held at premises NOT permanently occupied by you where the expected number of attendees would exceed 500?

Yes No

If yes, please provide details:

What is the expected number of attendees?

Do you perform any activities outside Australia?

Yes No

If yes, please advise type of activities and the countries where they are conducted.

Do you manufacture, import or export any Products?

Yes No

If yes, please provide full details of all Products manufactured, imported or exported, including the countries, over the last ten years:

Disability Care Comprehensive Insurance Proposal Form

Policy Coverage

General Public and Products Liability Section

Only complete this section if General Public and Products Liability Section is required.

Limit required:

- \$5,000,000
 \$10,000,000
 \$20,000,000
 \$30,000,000
 \$40,000,000
 \$50,000,000

Standard Excess:

- Nil
 \$1,000
 \$2,500
 \$30,000,000
 \$5,000
 Other

Note: an additional excess applies to claims for personal injury to subcontractors / contractors and / or volunteers. This will be detailed within our terms.

Optional Extensions	Required?
<p>Sexual Abuse:</p> <p><i>Note: a quotation may be provided, however cover will not be confirmed until a satisfactory "Prevention of Abuse" questionnaire is received. Please contact Ansvr for this form if required.</i></p> <p>Limit Required:</p> <p> <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000 <input type="checkbox"/> \$10,000,000 <input type="checkbox"/> Other <input type="text"/> </p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Replacement Wages of Stood Down Staff:</p> <p><i>Note: this extension is only available if we agree to provide cover for Sexual Abuse under Optional Extension 1.</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Medical Malpractice:</p> <p>Limit Required:</p> <p> <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000 <input type="checkbox"/> \$10,000,000 <input type="checkbox"/> Other <input type="text"/> </p> <p>Please advise the number of:</p> <p> <input type="checkbox"/> Enrolled nurses <input type="checkbox"/> Nursing practitioners <input type="checkbox"/> Registered nurses </p> <p> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p> <input type="checkbox"/> Other health care practitioners who are not required to be registered under National Law </p> <p> <input type="text"/> </p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Retroactive Liability (Prior Claims Made):</p> <p>Prior to insuring with Ansvr, was your previous liability cover on a "Claims Made" basis?</p> <p>If yes, please provide a copy of your most recent policy schedule so we can tailor this extension appropriately</p> <p>Limit required: <input type="text"/></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Member to Member Liability:</p> <p><i>Note: this extension will provide cover to your members, guests or visitors for their own personal liability if they cause bodily injury or property damage to other members of the general public whilst participating in an activity organised by you, subject to the policy terms and conditions.</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Trauma Counselling Costs:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Disability Care Comprehensive Insurance Proposal Form

Part B: Professional Indemnity

Only complete this section if Part C: Organisation Liability is required.

Activities

Please provide details of any medical examinations, treatments, medications that you or your professionally qualified staff might provide:

Are all persons who provide treatment registered, qualified and employed by you? Yes No

If no, please provide details:

Do you own in whole or part any clinic, hospital, sanatorium etc.? Yes No

If yes, please provide details:

Have you any ongoing or temporary arrangements to employ contractors on your premises (or intend entering into a contract) as part of your business? Yes No

If yes, please detail the nature and terms of the contract:

Please provide a copy of the contract as it relates to any insurance arrangements.

Prior Insurance

Prior Professional Indemnity insurance		
If you are selecting Professional Indemnity cover to replace an existing policy, please advise:	Current insurer:	
	Current policy number:	
	Current expiry date:	
	Current retroactive date:	
	Continuous cover in place since:	

Disability Care Comprehensive Insurance Proposal Form

Policy Coverage

Professional Indemnity Section

Only complete this section if Professional Indemnity Section is required.

Limit required for any one claim:

- \$1,000,000
 \$2,000,000
 \$5,000,000
 \$10,000,000
 Other

Standard Excess:

- \$500
 \$1,000
 \$2,500
 \$5,000
 Other

Part C: Personal Accident

Only complete this section if Part D: Personal Accident is required.

Activities

Please provide a description of the activities that the insured persons will be performing or participating in:

Policy Coverage

Note: the policy limits the Capital Benefits for all Insured Persons under the age of 18 years or over the age of 75 years to \$50,000 maximum.

	Required?
Category A: Your Volunteers for injury whilst performing volunteer duties Capital Benefits: <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 Weekly Benefits: <input type="checkbox"/> Nil <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 Benefit Period: <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks <input type="checkbox"/> 104 weeks Deferral Period (waiting period before weekly benefits will be paid): <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Required?
Category B: Your Students and / or Members for injury whilst participating in your activities Capital Benefits: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 Weekly Benefits (only relevant for income earners): <input type="checkbox"/> Nil <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Benefit Period: <input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks Deferral Period (waiting period before weekly benefits will be paid): <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No

Disability Care Comprehensive Insurance Proposal Form

Declaration

I/We declare:

- (a) The answers given and statements made are to the best of my/our knowledge true and correct, and that I/we have not withheld any information likely to affect the acceptance of this application or the terms on which it is accepted.
- (b) I/We have read and understood the Important Notices set out in the proposal and I/we are authorised to make this proposal.
- (c) It is agreed that the information contained in this proposal and any attachments will be the basis of the Disability Care Insurance contract between the named organisation and Ansvr Insurance Limited and is subject to the terms, conditions and provisions contained in the Disability Care Insurance Policy underwritten by Ansvr Insurance Limited.
- (d) That the information supplied in this proposal to Ansvr Insurance Limited for both the principal purpose of assessing this application for insurance cover and the secondary purpose of disseminating to the business entity information, notices and details regarding this insurance policy and services distributed or offered by Ansvr Insurance Limited.
- (e) That I/we have made all due enquiries necessary in order to comply with the Duty of Disclosure.
- (f) That I/we have read Ansvr's Privacy Policy and consent to the use, disclosure and obtaining personal information about the Insured for the purposes shown on the Privacy Statement.

Please tick the box if you do not wish to receive any marketing material from us.

Signature Date

Name Position

Attachments

Please attach to this proposal:

- (i) any documentation we have requested for the Sections of cover you require (including copies of your latest 2 annual reports, financial accounts, rules and procedures, codes of conduct);
- (ii) details of any other information which you think may affect your insurance or which we should be advised of (see "Your duty of disclosure"); and
- (iii) any additional information which may assist us to gain a complete appreciation of the nature of your business.

Notice to the proposed insured

Your duty of disclosure

It is a requirement of the Insurance Contracts Act 1984 and the Corporations Act 2001 that the following notices 1, 2, 3, 4, 5 and 6 be brought to your attention before you complete this proposal form.

1. Disclosure of relevant facts

Your duty of disclosure

Before you enter into a contract of insurance, you have a duty under the Insurance Contracts Act 1984 (Cth) to disclose anything that you know, or could reasonably be expected to know, that may affect the insurer's decision to insure you and on what terms. You have that duty after proposal, and up until the time the insurer agrees to insure you. You have the same duty before you renew, extend, vary or reinstate a contract of insurance.

You do not need to tell the insurer anything that:

- reduces the risk that is insured;
- is common knowledge;
- your insurer knows or should know as an insurer; or
- the insurer waives compliance with your duty of disclosure.

If you are uncertain about whether or not a particular matter should be disclosed to the insurer, please contact your Aon Client Manager.

Non-disclosure

If you do not tell your insurer anything you are required to, the insurer may cancel your contract or reduce the amount that it is required to pay you if you make a claim, or both. If your failure to disclose is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

2. Claims made and notified policy

This proposal is for a claims "made and notified" policy of insurance. This means that the policy covers you for claims made against you and notified to the insurer during the period of cover. This policy does not provide cover in relation to:

- events that occurred prior to the retroactive date of the policy (if such date is specified);
- claims made after the expiry of the period of cover even through the event giving rise to the claim may have occurred during the period of cover.
- claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy;
- claims made, threatened or intimated against you prior to the period of cover or any previous proposal form.

However, where you give notice in writing to the insurer of any facts that might give rise to a claim against you as soon as reasonably practicable after you become aware of those facts but before the expiry of the period of cover, the policy will, subject to the terms and conditions, cover you notwithstanding that a claim is only made after the expiry of the period of cover.

Upon expiry of the policy no further claims can be made thereunder and the need to maintain insurance or arrangement of Run-Off cover is essential. You should familiarise yourself with our standard form of policy for this type of cover before submitting this proposal.

3. Broker acting as agent of insurer

In effecting this contract of insurance the broker will be acting under an authority given to it by the Insurer and the broker will be effecting the contract as agent of the Insurer and not the Insured.

4. Claims notification

If you become aware of a claim or of circumstances that could give rise to a claim in the future, you should notify us in writing immediately, so that we can notify your insurer on your behalf. If you become aware of a claim or of circumstances and you do not notify them during the policy period, you could be left uninsured or facing a reduced payout from your insurer in respect of that claim or any future related claim.

5. Average provision

This policy provides that if a payment in excess of the limit of indemnity available under this policy has to be made to dispose of a claim. The insurer's liability for costs and expenses incurred with its consent shall be such proportion thereof as the amount of indemnity available under this policy bears to the amount paid to dispose of the claim. Any surplus will be deducted from claim payments.

6. Subrogation agreements

Where another person would be liable to compensate you for any loss or damage otherwise covered by the policy, but you have agreed with that person either before or after the loss of damage occurred that you would not seek to recover any monies from that person, the insurer will not cover you under the policy for any such loss or damage.

Aon's Privacy Statement

Aon has always valued the privacy of personal information. When we collect, use, disclose or handle personal information, we will be bound by the Privacy Act 1988. If you would like a copy of our Privacy policy, or wish to seek access to or correct the personal information we collected or disclosed about you, please telephone or email your Aon contact or access our website: aon.com.au

Office Use Only

Intermediary name

Account number

Policy number