

Disability Services Insurance Proposal



ansvar[®]
insurance

Disability Services Insurance Proposal



Office Use Only

Intermediary name

Account number

Policy number

Occupation code

Important notices

Duty of disclosure

Before you enter into a contract of general insurance with us, you have a duty under the Insurance Contracts Act 1984 to disclose to us every matter that you know, or could reasonably be expected to know, is relevant to our decision whether to accept the risk of insurance and, if so, on what terms.

You have the same duty to disclose these matters to us 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 us;
- that is of common knowledge;
- that we know or, in the ordinary course of our business, ought to know;
- as to which compliance with your duty is waived by us.

If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the contract of insurance in respect of a claim or may cancel the contract.

If your non disclosure is fraudulent, we may also have the option of avoiding the contract from its beginning.

Basis of Cover – Occurrence/Claims made

The cover provided under section 6 of the policy is in respect of occurrences during the period of insurance.

The cover provided under sections 7, 8 and 9 of the policy operates on a 'claims made' basis, which means you are covered for:

- claims made against you and notified to us during the period of cover, provided you were not aware at any time prior to the commencement of such period of any circumstances which could lead to a claim being made against you; and
- circumstances you first became aware of during the period of insurance which may lead to future claims, provided you notify us during such period of those circumstances.

The cover provided under sections 7, 8 and 9 is in respect of claims arising out of acts, errors, omissions or conduct that occurred after the retroactive date shown in the certificate of insurance. After expiry of the policy, no new claim can be made or circumstance notified under the policy even though the event giving rise to the claim may have occurred during the period of insurance, except where allowed by law.

Please ensure you have read the Disability Services insurance product disclosure statement and policy wording and the important notices in this application to assist your understanding.

If you require any assistance, please contact your insurance broker or your local Ansvar Insurance office.

Waiver of rights

The policy has a provision that limits or reduces our liability if you agree not to sue any liable party, or if you enter into any arrangement or compromise with such party, or waive or prejudice our rights of recovery as a result of any claim which would normally be covered under the policy.

Code of Practice and Privacy Act

As a signatory to the General Insurance Code of Practice we are committed to raising standards of service to our customers. This voluntary code sets out the minimum standards we will uphold in the services we provide to you.

The Privacy Act sets out how we are to collect, use, disclose and protect your personal information. It also describes the circumstances for you to access and, if necessary, correct your personal information.

You may access your personal information by contacting any of our offices. The information we collect is used to assist us to provide you with our general insurance products and to manage our relationship with you.

At times we rely on third party suppliers (agents, legal advisers, other insurance companies, assessors, investigators, loss adjusters, market research and mail houses) to perform specialised activities for us. Your personal information may be provided to them so that they can carry out their agreed activities.

They are bound by confidentiality and non-disclosure agreements and are prohibited from using the information for any other purpose. These service providers are aware of their obligations under the Privacy Act and the General Insurance Code of Practice.

If you do not wish to provide us with your personal information, we will not be able to supply our products to you.

How we can be contacted

The registered office of Ansvar Insurance Limited is Level 18, 303 Collins Street, Melbourne, Victoria 3000.

You can contact us by:

- visiting us at any Ansvar Insurance office
- telephoning 1300 650 540
- facsimile on 03 9614 1545
- writing to any office of Ansvar Insurance
- email to insure@ansvar.com.au

How to complete this proposal

All questions must be answered in relation to the business entity to be insured and all its subsidiary and controlled entities (if any). Please tick the box and/or write the information requested in the space provided. If there is inadequate space to answer any questions or to describe any matter you need to disclose to us, please provide this information on a separate signed sheet of paper or attach the relevant document to this application. Make sure all questions are answered and the form is signed.

1. Policyholder details *This section must be completed*

Name of organisation to be insured ABN/ACN/ARNM (one only) Date your organisation first commenced operations / /

Authorised contact person Telephone Fax

Mobile Email Website

Trading/former names of organisation (if any)

Organisational structure

Partnership Company limited by guarantee Public company
 Incorporated association Private company Unincorporated association
 Other *Please specify*

Postal address

Please advise the locations of properties where your organisation operates

Please describe the business activities of all entities to be insured by this policy

Please provide a copy of your last annual report, 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 business and the risk proposed

Do you envisage any substantial changes in your activities or are there any major new operations contemplated during the next 2 years? *If yes, please provide details* Yes No

Please give 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? *If no, please provide details* Yes No

2. Period of insurance *This section must be completed*

Required date of policy: Commencement date Expiry date at 4pm

3. General information *This section must be completed*

Has the organisation or its officers ever been charged and/or convicted of a criminal offence? Yes No

Has the organisation or its officers ever been declared bankrupt? Yes No

Has the organisation or its officers ever become insolvent or placed into liquidation or receivership? Yes No

If you have answered yes to any of the above questions, please provide details below

4. Previous insurance held by you *This section must be completed*

Has your aged care organisation held insurance in the last 5 years? Yes No

If yes, name of previous insurer/s

Expiry date

<input type="text"/>	<input type="text" value="/ /"/>
<input type="text"/>	<input type="text" value="/ /"/>
<input type="text"/>	<input type="text" value="/ /"/>
<input type="text"/>	<input type="text" value="/ /"/>
<input type="text"/>	<input type="text" value="/ /"/>

Have you ever had any insurance declined or cancelled, application rejected, renewal refused, claim rejected, special conditions or excess imposed by any insurer? *If yes, please provide details below*

5. Past insurance claims you have made *This section must be completed*

In the last 5 years have you ever claimed under a policy of insurance or is there now any claim pending against you or any other director/official of the entity applying for this insurance? *If yes, please provide details below*

Insurer	Date of incident	Description of loss/circumstance	Amount paid/outstanding
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="\$"/>

6. Details of the organisation premises *This section must be completed*

If you have more than two buildings at the one location or you have more than two locations, please complete additional applications

Address of the locations

Location one

Postcode

Location two

Postcode

Number of buildings at the location

a. Do you use the building for purposes other than noted above?

If yes, then please provide full details

Location one

Yes No

Location two

Yes No

For what purpose is the building occupied:

i. by you?

ii. by other parties?

b. What year was the building constructed?

c. If the building is over 30 years, has it been rewired?

Yes No

Yes No

d. *If yes to question c, date when it was last rewired?*

 / /
 / /

e. Construction of exterior walls

Concrete

Concrete

Timber

Timber

Brick

Brick

Other

Other

f. Construction materials of roof

Iron

Iron

Timber

Timber

Tiles

Tiles

Other

Other

g. Construction materials of floors

Concrete

Concrete

Timber

Timber

Other

Other

h. Are you aware of any asbestos material forming part of the buildings?

Yes No

Yes No

If yes, describe the type of material, quantity and your remedial plans

i. Describe the condition of the building/s

Good

Good

Fair

Fair

Poor

Poor

	Location one	Location two
j. Number of storeys (including ground)	<input type="text"/>	<input type="text"/>
k. Is the building connected to town water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If no, please advise details of water supply</i>	<input type="text"/>	<input type="text"/>
l. How are the premises protected against fire?		
i. Fire sprinkler system	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii. Smoke or heat detection equipment connected to the fire brigade	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii. Hose reels to cover whole floor area	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Portable fire extinguishers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes to iv, please advise</i>		
Number	<input type="text"/>	<input type="text"/>
Type	<input type="text"/>	<input type="text"/>
m. Do you have a commercial kitchen in your premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, detail the type of cooking equipment</i>	<input type="text"/>	<input type="text"/>
Do you have a deep fryer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the kitchen contain cooking hoods, filters and ducted exhaust system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are the hoods, filters and ducting cleaned by a service contractor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, what is the cleaning interval?</i>	<input type="text"/> months	<input type="text"/> months
n. How are the premises protected against burglary?		
Doors	<input type="text"/>	<input type="text"/>
Windows	<input type="text"/>	<input type="text"/>
Lighting	<input type="text"/>	<input type="text"/>
i. Do the premises have an alarm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, is it monitored?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who is the security company?	<input type="text"/>	<input type="text"/>

7. Employee and/or volunteer details

a. i. How many employees do you have?

 Employees professionally qualified* Employees unqualified

* Qualified refers to those people who hold a recognised university degree/diploma/certificate or industry equivalent.

ii. What is your annual wage role? \$

iii. How many volunteers do you have?

Policy Coverage

Section 1. Property

Do you require cover on your buildings and contents? Yes No

Declared values for insured property

Buildings including fixtures and fittings

General contents and property you are responsible for

Other specified contents (*please attach a separate list of all specified contents*)

Extra costs to comply with Acts of Parliament or other regulatory bodies:

limited to 15% of the declared value of buildings *or*

Removal of debris:

limited to 15% of declared values or \$500,000

Location one

Replacement value

\$

\$

\$

Location two

Replacement value

\$

\$

\$

Amount required

\$

\$

Section 2. Interruption insurance

Do you require consequential loss cover? Yes No

Indemnity period required? 12 months 18 months 24 months

Gross income including all money paid or payable to you

\$

Do you wish to select the following Optional extensions?

What sum insured is required?

1. Additional increase in cost of working

Yes No

\$

2. Accountants and other professional costs for claims preparation

Yes No

\$

3. Book debts

Yes No

\$

Section 3. Crime

This section offers cover under three parts. Please select the parts you require:

Note: the cover applies across all locations you have declared under Section 1 of this policy.

Part A. Loss of money (but not theft by your employees/officials)

Yes No

Part B. Burglary or theft of property (other than money)

Yes No

Part C. Theft by officials (of your money or property)

Yes No

Part A. Loss of money

Limit of money required? (Note: a limit of \$500 applies outside business hours)

\$

Do you wish to increase the limit outside business hours? Yes No

If yes

\$

Part B. Burglary or theft of property (other than money)

Please nominate sum insured \$5,000 \$10,000 \$15,000 \$20,000 Other *Please specify* \$

Are there any items of significance? *Please list*

Value

\$

\$

\$

Part C. Theft by officials

Insured property

How many people have responsibility for cash/cheques/negotiable instruments?

How often are your auditing requirements carried out?

Do you have clear procedures for handling money and for payments being made? Yes No

Please nominate a sum insured for money and all other property of the insured (not excluded by this section)

\$5,000 \$10,000 \$15,000 Other *Please specify*

Limits apply to extensions available under this section. Please refer to the policy wording for details.

Bank account control

Do the employees who reconcile the monthly bank statements either:

Sign cheques Yes No

Handle deposits Yes No

Do the employees who prepare cheques also sign the cheques? Yes No

Computer control

Is access to computers password controlled? Yes No

Do persons other than employees have physical or electronic access to computer facilities? Yes No

Is the output regularly reconciled and cross checked by persons who do not prepare or process input? Yes No

If you answered no to any of the above, what are the alternative controls in place?

Section 4. Glass breakage

Do you require glass breakage cover? Yes No

We cover you for the actual cost of replacing or fixing glass which suffers accidental breakage.

Extension and standard limit

Do you wish to increase the standard limits for any extensions?

	Standard limit			If yes, limit required
Frames and signs	\$5,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ <input type="text"/>
Temporary shuttering, sign writing	\$5,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ <input type="text"/>
Destruction of contents	\$5,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ <input type="text"/>

Section 5. Breakdown of mechanical and electronic equipment

This section offers cover under two parts. Please select which parts you require:

Part A. Breakdown of mechanical equipment (including boilers and pressure vessels) Yes No

Part B. Breakdown of electronic equipment Yes No

Part A. Specified mechanical equipment to be insured

	No. of items	New replacement value each item/sum insured
1. Central roof air conditioning	<input type="text"/>	\$ <input type="text"/>
2. Window/split system air conditioning	<input type="text"/>	\$ <input type="text"/>
3. Central heating	<input type="text"/>	\$ <input type="text"/>
4. Radiators/space heaters	<input type="text"/>	\$ <input type="text"/>
5. Refrigerators/freezers	<input type="text"/>	\$ <input type="text"/>

	No. of items	New replacement value each item/sum insured
6. Printing equipment	<input type="text"/>	\$ <input type="text"/>
7. All other equipment greater than \$2,000.	<input type="text"/>	\$ <input type="text"/>
Additional items to be insured as per listing attached		
Total new replacement value		\$ <input type="text"/>

Optional extension to Part A. Deterioration of refrigerated goods cover

Do you wish to select this optional extension? Yes No

Note: It is only available if you have insured all the refrigeration equipment under this section. Limit of loss under the policy is \$3,000

Type of goods being stored

Total value of refrigerated goods being stored at any one time? \$

Part B. Specified electronic equipment to be insured

	No. of items	New replacement value each item/sum insured
1. Audio visual equipment	<input type="text"/>	\$ <input type="text"/>
2. Computer/office equipment	<input type="text"/>	\$ <input type="text"/>
3. All other equipment greater than \$2,000	<input type="text"/>	\$ <input type="text"/>
4. <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
5. <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
6. <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
7. <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
Total new replacement value		\$ <input type="text"/>

Optional extensions available under Part B. Breakdown of electronic equipment

		Replacement value
1. Data media material and records	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <input type="text"/>
2. Increase in cost of working cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <input type="text"/>

Section 6. Liability insurance

Do you require this liability insurance cover? Yes No

Your chosen limit of liability \$5 million \$10 million \$15 million \$20 million

Do your premises have the following facilities?

Pools, sporting courts, golf courses etc. *Please specify* Yes No

Gymnasium/training rooms/playgrounds Yes No

Are all your facilities fully compliant with current Australian Standards and Government by-laws? *If no, please provide details* Yes No

Are your premises licensed to serve alcohol? Yes No

Do you operate any income generating businesses or activities eg. op shops? *If yes, please provide details* Yes No

Do you manufacture any items for sale? *If yes, please provide details of items and processes* Yes No

Do you sell any items which are manufactured by others? *If yes, please provide details of items sold*

Yes No

If yes, are you the sole agent within Australia for any items sold?

Yes No

What fundraising activities will disability services organisation be operating, running or involved with in the next 12 months? *Please provide details*

Please advise the number of persons in the following categories who provide services on your behalf:

Doctors	<input type="text"/>	Physiotherapists, Podiatrists	<input type="text"/>
Other therapists	<input type="text"/>	Registered nurses	<input type="text"/>
Enrolled nurses	<input type="text"/>	Attendant carers	<input type="text"/>
Other medical, health or allied employees	<input type="text"/>	Clerical/administrative	<input type="text"/>
Kitchen/catering/laundry	<input type="text"/>	Counsellors	<input type="text"/>
Other, <i>please specify</i>	<input type="text"/>		

Do you have or have you updated your documented incident reporting procedures in the last year?

Yes No

If yes, please provide details

Do you have a risk management program in place?

Yes No

This policy automatically covers the following activities:

Fetes or similar, outings, organised games, op shops, camps and excursions, fundraising such as walkathons and picnics.

Over the next 12 months will you provide or be involved in off-site/high risk activities? *If yes, please complete the following:*

Yes No

Activity <i>Please specify all activities</i>	Number of times held per year	Estimated number of participants per activity	Are the activities run by an external party?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you any ongoing or temporary arrangements to employ contractors on your premises (or intend entering into a contract) as part of your business? *If yes, please detail the nature and terms of the contract* Yes No

Name	Office/position held	Date of appointment	Details of professional association membership
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Are background checks and procedures in place for all new employees? Yes No

Please advise the number of beds you have in the following categories:

Retirement Village/I.L.U's	<input type="text"/>	Nursing Home – high care	<input type="text"/>
Hostel beds	<input type="text"/>	Community Aged Care Packages	<input type="text"/>
Extended Aged Care at Home (EACH)	<input type="text"/>	Palliative Care	<input type="text"/>
Respite Care	<input type="text"/>	SRS Units	<input type="text"/>
Other, <i>please specify</i>	<input type="text"/>		

Do you provide an Emergency Response Service? Yes No

If yes, is the service contracted to professional service providers? *Please provide details*

Do you comply with the Department of Health and Disability Services National Guidelines? Yes No

If no, please provide details

Do you have policies and procedures in place regarding patient care including the administering of medication? Yes No

If yes, please provide details

Do you provide any special therapy or activity facilities at your premises? eg. pools, spas, craft or woodworking, sporting facilities Yes No

If yes, please provide details

Do you ensure that all nursing staff employed by you or that provide services to your organisation are fully qualified, registered and licenced to perform all relevant activities required Yes No

Do you intend to undertake any construction/renovation of your premises in the next year? Yes No

If yes, please provide details

Are all external pathways, roads and carparks sealed and in good repair, with slip resistant surfaces? Yes No

If no, please provide details

Do you own one or more premises which are leased to the public or used by community groups? Yes No

If yes, please provide the following details

The number of premises utilised

The approximate number of times per year the premises are leased

Occupation of tenants (*please list on a separate page*)

Property in your care, custody and control

Do you require more than the standard limit of \$100,000?

Yes No

Do you require insurance for property in your care, custody and control?

Yes No

If yes \$

Molestation/sexual abuse cover

Does your organisation require cover against molestation/sexual abuse? *If no, proceed to section 7*

Yes No

If yes, please provide a copy of your working with children protocols

How often are adults formally left alone with children/young people on a one-on-one basis? Times per week Hours per week

If you employ people to work in child-related employment, you have obligations under the State Working With Children legislation. A Prohibited Employment Declaration must be sought from anyone applying for child-related employment, including volunteers. Have you obtained these declarations from all your paid and volunteer employees who are working in child-related employment?

Yes No

A background check is mandatory for any person working with children. Do you undertake police checks for all people who care for, work with or are involved with children or young people?

Yes No

Do you interview and check references of all people applying to work with, care for or be involved with children or young people?

Do you have a child protection policy with procedures for dealing with abuse complaints?

Yes No

Have you ever received complaints relating to molestation/sexual abuse or similar?

Yes No

If yes, please provide details on a separate page and attach to this declaration

Are you aware of any person who attends or is involved with your organisation and has previously committed a molestation or child abuse offence? **IMPORTANT:** Please be aware that your policy includes a 'Sexual Abuse Exclusion by Known Offenders.' *If yes, please provide details on a separate page and attach to this declaration*

Yes No

Our liability for all compensation relating to molestation/sexual abuse is limited to the amount shown in the certificate of insurance. Please contact your insurance intermediary or your local Ansvar Insurance office if you require a different limit.

Yes No

Section 7. Professional indemnity insurance

Do you require professional indemnity insurance cover?

Yes No

Is it the intention that the proposed insurance replaces an existing policy?

Yes No

What limit of cover do you require \$2 million \$5 million \$10 million \$20 million

Excess you will carry \$500 (min.) \$1,000 \$2,500 Other amount, *please specify*

Section 8. Liability of officials

Do you require liability of officials insurance cover?

Yes No

Is it the intention that the proposed insurance replaces an existing policy?

Yes No

What limit of cover do you require \$2 million \$5 million \$10 million

Excess you will carry \$1,000 \$2,500 \$5,000

Please provide the name and position of each director or senior officer of the business entity:

Name	Office/position held	Date of appointment
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

If the business entity is a subsidiary of another company, please indicate the name of the ultimate holding company:

Do any shareholders own directly or beneficially 10% or more of the shares? *If yes, please provide details*

 Yes No

Is the business entity and/or its shares listed on a recognised stock exchange or a recognised secondary market?

 Yes No

If yes, please provide details

Please provide details of any companies or businesses acquired or disposed of by the businesses acquired or disposed of by the business entity during the last 18 months:

Is the business entity considering any:

 acquisition? disposal? tender offer? merger?

If yes, please provide details of any other business or company involved

Please state any changes that will be made to the list of subsidiaries detailed in the business entity's latest available accounts as a result of any acquisition, creation, divestiture, liquidation or disposal made since the last balance sheet date:

Name	% Equity share capital held	Disposed or acquired
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

An outside directorship is a position as director or responsible public officer of any body which is not the business entity or a subsidiary of the business entity and which position is held with the knowledge and agreement of the business entity.

Does the business entity require cover for any outside directorship? *If yes, please provide details on the following:*

 Yes No

Name of body

Activities or business

Its insurance arrangements

Insurer

Sum insured or indemnity limit

Expiry date of insurance cover

Amount of excess

Has the business entity ever been refused this type of insurance or had a similar insurance cancelled?

 Yes No

If yes, please provide details

Have you held directors and officers liability insurance before? *If yes, please provide details of insurance for the last three years*

 Yes No

Insurer	Period of cover	Limit of liability	Deductible
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Current retroactive date

a. Accident only (These questions relate to all applicants)

Have you any physical defect or infirmity? *If yes, please provide details*

Yes No

b. Illness You need to complete this section of the form if you require cover for illness

(Note: no compensation is paid for illnesses not exceeding one week)

Are the people covered under this policy currently in good health?

Yes No

Are the people covered under this policy currently aware of anything which may at any time render necessary a surgical operation? *If yes, please provide details*

Yes No

During the last six weeks, have any of the people covered by this policy been exposed to any infectious diseases? *If yes, please provide details*

Yes No

Give particulars of illnesses during the last five years which have disabled any of the people covered by this policy for more than a week. *Please provide dates and duration of such disablement*

Have any of the people to be covered under this policy ever had any of the following illnesses?

Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Haemorrhoids/piles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pleurisy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any central nervous system disease/disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any lung condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fistula	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details surrounding illness

Section 11. Volunteers – personal accident

Do you require volunteers personal accident cover?

Yes No

How many volunteers might you engage at any one time?

How often do you have volunteers undertaking activities?

What type of activities will they undertake for you?

How much death and permanent total disablement benefit do you require?

\$10,000 \$20,000 \$50,000 Other *Please specify* \$

How much weekly benefit do you require? \$100 \$200 \$500 Other *Please specify* \$

Note. An initial period of 7 days disablement is excluded. Do you require a change in this?

Yes No

If yes, how many days?

Excess**The following are the minimum excess applicable for each policy section.**

Increasing your excess will reduce the premium payable:

	Minimum excess	Alternative excess required
Section 1 and 2 Earthquake, or volcanic eruption	\$20,000	\$
Named cyclone excess	\$10,000	\$
All other loss/damage	\$250	\$
Section 3. Earthquake	\$300	\$
Section 4	\$250	\$
Section 5	\$250	\$
Section 6	\$250	\$
Section 7	\$250	\$
Section 8	\$250	\$
Section 9	\$250	\$
Section 10	7 days	\$
Section 11	\$250	\$
Section 12	\$250	\$

Additional information (if any)

Is there any other information which you think may affect your insurance or which we should be advised of?
(See your 'Duty of Disclosure' on page 2). *If yes, please provide details on a separate page and attach to this declaration.*

Yes No

Declaration *This section must be completed*

I/we declare that 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 declaration or the terms on which it is accepted.

I/we acknowledge that I/we have received a copy of the Ansvar Insurance PDS and policy setting out the terms and conditions which apply to this insurance. I am/we are aware that I/we have twenty one days to read the policy and if I am/we are not satisfied with the conditions I/we can cancel this insurance in writing and receive a full refund of any premium paid.

Applicant(s) signature

Signed

Position

Date

Completion of this form does not provide insurance until a Cover Note or Certificate of Insurance has been issued.

Notes

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