CLEAR

Placement Agencies

Professional Liability Supplemental Application

THIS SUPPLEMENTAL APPLICATION IS PART OF THE PROFESSIONAL LIABILITY APPLICATION, INCLUDING CLASS SPECIFIC AND RENEWAL APPLICATIONS, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE CONDITIONS AND REPRESENTATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENTAL APPLICATION.

PLEASE ANSWER ALL QUESTIONS AND LEAVE NO BLANK SPACES. IF THE SPACE PROVIDED IS INSUFFICIENT TO ANSWER ANY QUESTION FULLY, KINDLY APPEND A SEPARATE PAGE WITH YOUR DETAILED ANSWERS.

Enclose the following with this Application:

i. ☐ Copy of the Applicant's standard written contract with the leased or placed personnel.

ii. ☐ Copy of the Applicant's standard written client service agreement (for business clientele).

APPLICANT

1. Name: _____

BUSINESS ACTIVITIES AND FINANCIAL INFORMATION

2. Does the Applicant provide any of the following screening services:

- Administer job testing Yes ☐ No ☐
- Verify professional and academic credentials Yes ☐ No ☐
- Perform background checks Yes ☐ No ☐
- Provide drug testing (via a third party) Yes ☐ No ☐
- Other (describe): _____

3. Complete the following table describing each service and indicate the approximate percentage of revenue derived from each.

Services	% (total must be 100%)
Temporary Placement	%
Permanent Placement	%
Employee Leasing	%
Recruitment	%
Other (describe):	%

4. Please provide the type of leased or placed personnel (executive, clerical, etc.): _____

   For healthcare personnel, please detail your answer in questions 7 and 8.

5. Does the Applicant do the placement or leasing of non-residents? Yes ☐ No ☐

   If Yes, please submit all details.

   _____

6. What is the annual salary paid by the Applicant to leased or placed personnel?
   (Note: that amount must be included in the gross annual revenue specified in the Professional Liability Application)

   Past year: _____ est. for current year: _____ est. for next year: _____

HEALTH CARE PLACEMENT AGENCIES

☐ Check the box if no such services are provided

7. Complete the following table describing your personnel and indicate the approximate number of personnel derived from each.

Personnel	Number of Personnel
Registered Nurses	
Licensed Practical Nurses	
Nurses Aids / Orderlies	
Personal Support Workers	
Personal Support Workers rendering services according to Bill 90 (only in Quebec)	
Other (describe):	

8. Indicate the approximate percentage of revenue derived from each of the following. *(Total must be 100%)*

Type of Clients	% (total must be 100%)
Institutions (Hospitals, Nursing Homes, etc.)	%
Private Homes	%
Other (describe):	%

The undersigned authorized representative of the Applicant declares that the statements in this Supplemental Application and any attachments or information submitted with this Supplemental Application are true and complete. The undersigned understands that this Supplemental Application and any such attachments or information submitted herein are part of the Application submitted by or on behalf of the Applicant for the proposed insurance and are subject to the conditions and representations set forth therein.

Applicant name (print): _____ Date: _____

Applicant signature: _____ Applicant title: _____