

BROKER QUOTE FORM

Email completed form to info@direct2networks.co.uk or fax to 0845 272 3526

GENERAL COMPANY INFORMATION

Title of Insured:

Trading name:

Risk Location:

Address Line 1:

Address Line 2:

Town:

Post Code:

Business Description:

Renewal Date:

Current Insurer:

Premium Paid:

Year Established :

Please state the approximate percentage division of your patients/residents between the following Service User Categories: Please tick answer(s)

Dementia :

Elderly :

Mental Disorder :

Learning Difficulties :

Physical Disability:

Drugs :

Alcohol :

Terminally ill:

Sensory Impairment :

Other:

RISK MANAGEMENT

Date of last survey :

Who carried out last survey (Insurer/Broker)?

Details of outstanding recommendations?

Does Insured have a Health & Safety policy?

Are premises in a good state of repair?

Are you aware of any subsidence or landslip problems in your local area?

(Please tick answer)

Yes

No

SECURITY

Door locks:

Window locks:

Intruder Alarm Type:

Fire Protection (Please provide full details)

Sprinkler:

Extinguishers:

Hose Reels:

Fire Alarm:

Deep Fat Frying:

Was your current Health & Safety Policy created by your own staff?

Is responsibility for your health, safety and safeguarding issues designated to a senior manager/leader?

STANDARD COVER AND YOUR INDIVIDUAL REQUIREMENTS

SUMS INSURED

Property

1. Buildings declared value:
2. General Contents declared value:
3. Tenants Improvements:
4. Owners Personal Effects:
5. Residents Effects:
6. Computer Equipment:
7. Frozen Food:

Business Interruption

1. Annual Revenue:
2. Rent Receivable: Indemnity Period (24, 36 months):
3. Gross Profit:
4. Increased cost of working:
5. Book Debts:
6. Extensions:
7. Deductible:

Buildings:

Machinery/Plat/Fixtures 7 Fittings:

Stock / Work in progress:

Wines & Spirits sum insured:

Tobacco sum insured:

Loss of License:

Computers and electrical business equipment:

All other Items (Specify):

GLASS BREAKAGE

All Glass/External Glass/Internal Value:

PUBLIC AND PRODUCTS LIABILITY

Limit of Indemnity:

EMPLOYEE LIABILITIES - Annual Wages Declaration

Number of Staff:

Total Annual Wages £

Please provide split in wages as follows:

1. Directors and Officers £
2. Carers £
3. Domiciliary Carers £
4. Office/Administration £
5. Maintenance £
6. Chefs and Kitchen Staff £
7. Waitress/Foodservice £
6. All other wages £

How many full and part-time staff do you have?

Full-time:

Part-time:

Money (Please provide full details)

Money on Premises:

During Business Hours:

In Dwelling of Insured/Employee:

In Safe:

Details of Safes and Limit per safe:

Please provide make/model and serial number of safes in which money is kept:

1. Make Model Serial No.
2. Make Model Serial No.

How many people have keys and access to the safe?

Do you comply with all legislation and guidelines applicable to your activities relating to the safeguarding of children/young people/ vulnerable adults where appropriate the use of the criminal record Bureau's Disclosure Service?

Do any persons in your care have learning disabilities, mental disorders, dependencies or may they be described as displaying 'challenging', 'anti-social' or other behavioural difficulties?

Do you undertake activities away from your premises involving those in your care?

Do you keep records of abuse allegations or incidents including notification to the appropriate authorities?

Yes No

Does your business activities include providing domiciliary care?

Yes No

If 'Yes', please confirm estimated revenue in respect of domiciliary care:

Please confirm estimated wage figure in respect of domiciliary care:

Additional Information