Healthcare Professional Application
Healthcare Facilities

CNA
We can show you more.®

Instructions

This Application and all materials submitted shall be held in confidence.

All questions must be fully answered and all requested information and/or required attachments submitted to enable a quotation or indication to be given. However, the completion and submission of this form does not bind the applicant or underwriters to enter into any contract of insurance.

If a question does not apply, please write "N/A". If the answer is none, state "none". If more space is needed, please continue on a separate sheet of the applicant's letterhead and indicate the question number to which the information responds. This Application and any separate continuation sheets must be completed, signed and dated by a principal of the business.

It is your duty to disclose to underwriters all facts material to the proposed insurance. Failure to do so could prejudice your rights to recover in the event of a claim or allow underwriters to void the policy. A material fact is one likely to influence the underwriters' assessment or acceptance of the Application.

Applicant Information

1. Name of Insured(s)

   _____

   _____

2. Registered Office Address

   _____
   Address

   _____
   City Province Postal Code

3. Website _____

4. Please provide a brief business description.

5. How many years has the applicant been in operation? _____

6. Is the Applicant an accredited facility? **Yes** **No**

   Accrediting Body: _____

   Last Year Accreditation awarded: _____ / _____ / _____
   mm dd yr

7. Please give details of your current and previous medical malpractice insurance.

	Current Year	**Previous Year**
Insurance Company		
Limits of Liability		
Deductible		

   Basis of Current Insurance Cover:

   Claims-Made Retroactive Date _____ / _____ / _____ **Occurrence**
   mm dd yr

8. Requested Effective Date _____ / _____ / _____
   mm dd yr

9. What 'Any One Claim' Limit of Indemnity does the applicant require? (please check)

   2mm 5mm 10mm Other (specify) _____

10. What Aggregate Limit of Indemnity does the applicant require? (please check)

    2mm 5mm 10mm Other (specify) _____

11. Indicate the gross revenue from applicant's facility(ies).
    (If more facilities exist, please attach a separate sheet of paper and provide the information requested below for each facility)

    Gross Revenue: Prior Year: _____ Current Year: _____ Projected: _____

12. Organization Type **For Profit** **Not for Profit**

13. On the following page, please Indicate all services provided by choosing all that apply:
    This information is the basis for rating the submission. If the response includes other, provide receipts and treatments.
    Annual # of Procedures are defined as the number of patients entering the facility for health-related services per year. Where a service includes contacts falling into more than one of the below classifications (for example, telephone triage followed by out of hours visit), please only complete the main classification:

Type of Centres	Services Provided	Annual # of Procedures
Surgery Centres	Cardiac: Catheterization Cardiac: Other (describe) Chiropractic: Other (describe) Dental, Oral and Maxillofacial Endoscopy / Colonoscopy Gastro-Intestinal / GI Surgery Gynecologic Surgery Injection (Joint, Spinal, Trigger) Liposuction Ophthalmology: LASIK procedures Ophthalmology: Other than LASIK Orthopedics Plastic / Aesthetic Surgery Podiatric Surgery Urological Surgery Weight Loss Surgery Other: (please specify)	

Type of Centres	Services Provided	Annual # of Procedures
Imaging Centres	CT MRI PET Ultrasound: Obstetric Ultrasound: (non-Obstetric) X-Ray Other: (please specify)	

Type of Centres	Services Provided	Annual # of Procedures
Laboratories	Cytology DNA/Genetic Testing Endocrinology Hematology Paternity Testing Pathology Research Sperm Bank Toxicology Other: (please specify)	

Type of Centres	Services Provided	Annual # of Procedures
Multi-disciplinary Clinics		

Type of Centres	Annual # of Procedures
Cancer Treatment Centres	
Diagnostic Clinics	
Dialysis	
Drug & Alcohol Rehabilitation Centres	
Pharmacies	
Physical Rehabilitation	
Walk-in Clinics	

Type of Centres	Annual # of Procedures
Hospices	# of beds _____
Nurse staff	Full time Equivalent (FTE) Nurses placed: _____

14. Do you provide services to Non Canadians? If yes, what percentage are: U.S. Residents _____ %

15. Supervising Doctors/Dentists/Dental/Oral Surgeons

Specialty	Total Number of Registered Medical/ Dental Practitioners	Full time Equivalent (FTE) *1 FTE = 40 hours/week*	Full time Equivalent (FTE) *Independent Contractor*

16. Are there any registered medical/dental practitioners that *are not* members of medical/dental defense organizations and *are not* fully indemnified for their own malpractice nor are otherwise insured for all work undertaken on your behalf?

Employed? **Yes** **No**

Independent Contractor? **Yes** **No**

If 'Yes', please explain.

17. Have any of employed/self-employed doctors/dentists been subject of disciplinary proceedings for professional misconduct?

Yes **No**

If 'Yes', please explain.

18. Healthcare Professionals *Please attach list of all employed and contracted healthcare professionals and their specialization.*

	Total Number	**FTE Employed**	**FTE Independent Contractor**
Registered Nurse (prescriptive authority)			

Do you have nurse practitioners on site with prescriptive authority? If yes, provide the number: _____

19. Please provide details of any new activities or developments that are likely to occur within the next 12 months (i.e. new construction projects or new clinical programs). If none, state "none".

20. Clinical trials: Does the applicant sponsor any clinical trials? **Yes** **No**

21. Are there any known contractual obligations where the Applicant has to provide insurance on behalf of another medical provider or hold another medical provider harmless?

Yes **No**

If yes, list and state purpose:

Name	**In connection with:**

22. Does the applicant work with Professional Athletes? **Yes** **No**
If yes, please provide a description.

23. Please complete the following to the best of the Applicant's knowledge at the time of signing the Application:

a. Does the applicant have a formal written Risk Management Process in place? **Yes** **No**
If yes, please provide the latest report provided to the governing body, if applicable, and a brief description of the internal reporting process.

b. Procedures for formal incident reporting are clearly documented and implemented throughout the Applicant's organization. **Yes** **No**

c. Is there a formal medical record (electronic or paper) retention policy or process in place? **Yes** **No**

d. Is a patient complaint management procedure in place and appropriately reported to senior executives? **Yes** **No**

e. Formal mechanisms are in place for selection, recruitment, orientation, and performance management of all employees and independent medical staff. **Yes** **No**

f. Is there a formal mechanism in place for credentialing and privileging of medical staff? **Yes** **No**

g. The Applicant is in compliance with all regulatory workplace health & safety requirements **Yes** **No**

h. The applicant disposes of all waste in accordance with regulatory requirements **Yes** **No**

i. The Applicant sterilizes instruments in accordance with current best practices guidelines **Yes** **No**

j. Applicant complies with manufacturer guidelines with respect to single-use products, devices or equipment **Yes** **No**

25. Does the Applicant/Company have locations, operations or employees outside of Canada i.e. USA or other? **Yes** **No**
If yes, please provide details:

For each of the following questions, if you answer "Yes", please provide details on a separate sheet and attach to the application.

26. Has the applicant had any medical professional, or general liability claims or suits brought against it in the past 5 years? **Yes** **No**

27. Is the applicant aware of any incident, circumstance or occurrence which may result in a claim and which has not been reported to another carrier? **Yes** **No**

28. Has the facility/operational registration ever been suspended, revoked or voluntarily suspended? **Yes** **No**

29. Has any insurance company or Lloyd's Syndicate declined, cancelled, or refused to renew or accept any of the applicant's liability insurance? **Yes** **No**

30. Has any company with whom the applicant has been previously affiliated, become insolvent? **Yes** **No**

31. Has the applicant or any of its officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by any professional medical society, accreditation agency, or other governmental or non-governmental oversight entity? **Yes** **No**

Please enclose any lists or explanations as required in response to various questions throughout the body of the insurance Proposal. In addition, please provide copies of the following:

- **Claim loss runs for the past five (5) or more years for all coverages for which you are applying, in Excel format, if available.**
- **Sample contract reflecting applicant's requirements for indemnification and liability insurance coverages from other parties**

Warranty Statement

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution and confinement in state prison.

Completing and signing this application does not bind coverage. Coverage will not be bound, nor will a policy be issued until the applicant signifies acceptance of the Company's premium quotation.

The undersigned authorized officer of the applicant knows of no other relevant facts which might affect the Company's judgment when considering this renewal application and warrants that the statements herein are true, and it is agreed that this renewal application shall be the basis of the renewal contract and shall be deemed incorporated therein should the Company evidence its acceptance of this renewal application by issuance of a renewal policy. It is agreed that this renewal application shall be on file with the Company and that it shall be deemed to be attached to and made part of the renewal policy, if issued, as if physically attached to the renewal policy.

_____

Signature in Full

_____

Name *(Please print.)*

_____

Position in Company *(Please print.)*

_____

Date

Please complete and return this form to your insurance broker.