Specialties

Healthcare Professional Application
Healthcare Facilities

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 General Information

1. Name of Insured(s): _____

2. Registered Office 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: Month _____ Day _____ Year _____

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: Month _____ Day _____ Year _____ **Occurrence**

8. Requested Effective Date: Month _____ Day _____ Year _____

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 explain.

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 executive? ◯ 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

24. 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.

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

26. 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

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

28. 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

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

30. 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,f available.**
- **Sample contract reflecting applicant's requirements for indemnification and liability insurance coverages from other parties.**

Warranty Statement

Applicant declares that the information provided in this Application, as well as any supplemental information attached to this Application, is true, accurate and complete, and that no material facts have been omitted. Applicant acknowledges a continuing obligation to report to the CNA Company to whom this Application is made ("CNA"), as soon as practicable, any material changes in all such information, after signing the Application and prior to issuance of the policy, and acknowledges that CNA shall have the right to withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance based upon such changes. Whereas completion of this Application and signing it does not bind coverage, the Applicant acknowledges and agrees that this Application shall be the basis of the contract if a policy is issued, and that if a policy is issued, CNA will have relied upon, as representations, the Application and any supplemental information attached to this Application, all of which are incorporated by reference to this Application and made a part hereof. Applicant acknowledges that the misrepresentation or failure to disclose material information in the Application could result in a denial of coverage or the issued policy being voidable or void.

Applicant:

By: _____ _____

*Signature and Title** *Printed Name of Authorized Representative*

Date: _____

*** This Application must be signed by the Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, General Counsel or Risk Manager**