Healthcare

Professional Application – Healthcare Facilities[1]

Instructions

This is an application for a CLAIMS MADE POLICY. Should this application be accepted by the Company, coverage will apply to claims first made against the insured during the policy period. No coverage will apply for claims first made against the insured after the end of the policy period unless the extended reporting period applies. No coverage will apply for claims first made prior to the retroactive date shown in the declarations page of the policy. The completion and submission of this application to the Company does not constitute a binder of insurance.

All questions must be answered. If a question is not applicable, please answer "N/A." If the answer to a question is none, state "None" or "0". If more space is required to answer a question completely, please provide a separate attachment and identify the question it responds to.

Section 1 – General Information

1. Name of Applicant (Please print): ______________________________

Mailing Address: ______________________________

City/Town:____________________ Province:____________________Postal Code: ____________

Phone:____________________ Email:______________________________

Website: ______________________________

Location(s) other than that listed above:______________________________

2. Are you a current policyholder or a new Applicant? Existing Holder New Applicant

3. What is the legal structure of the business? (check appropriate box)

Sole proprietorship (unincorporated) Profession corporation Partnership

Sole proprietorship (incorporated) Association/group Group practice

Other (describe):______________________________

4. What is tax status of the business? For profit Not for profit Government

5. Date of incorporation: ____________________

6. List any subsidiary or affiliate (e.g., research organization) controlled by the Applicant that requires insurance coverage.

Name of Entity	Relationship to Applicant	Description of Operations	Country of Domicile

[1]This includes ambulatory surgical centres (ASC), diagnostic imaging (DI) centres and physicians' offices

7. List all licenses held by your business, including type and expiration dates:____

Were any conditions or restrictions placed on the operations of the Applicant by the licensing body? Yes No

If yes, give full details here:____

8. List all accreditations (e.g., Accreditation Canada, CLIA, ASMBS) and association memberships held by the Applicant:

____ Last year accreditation awarded: ________________

9. Does the Applicant provide professional services over the internet? Yes No

If yes, please provide a description of the services: ____

10. Please state sources and amounts of gross annual revenue for the following years (in CAD):

	Last complete financial year	Estimate for current financial year	Estimate for next financial year
Canadian revenue			
USA revenue			
Total revenue			

11. What percentage of patients treated are:

Canadian residents: ____________% USA residents: ____________% Non-Canadian/Non-USA residents: ____________%

12. How many visits/consultations/treatments/tests/procedures were performed during the past year? ____________________

13. In the next 12 months, are there any intended substantial changes to the Applicant's professional services or major new developments likely? Yes No

If yes, please provide full details: ____

Section 2 – Coverage

1. Please provide details of your current and previous medical malpractice insurance.

Insurer	Term	Limit	Deductible	Premium

i. Basis of current insurance coverage: Claims-made: Retroactive date (dd/mm/yyyy)______________ Occurrence

2. Coverage Requested: ____

i. Effective date of coverage (dd/mm/yyyy) ____________

ii. Limit of liability $1M $2M $5M $10M Other: $______________

iii. Deductible $1K $2.5K $5K $10K Other: $______________

iv. Aggregate $1M $2M $5M $10M Other: $______________

Section 3 – Applicant Information

1. For the previous 12 months: indicate all services that apply, the percentage of total gross revenues for that service, and the annual number of those services delivered.

	Relative % of Revenue	Annual # of Tests/Visits[2]
Diagnostic Centre:		
X-Ray		
CT Scan		
MRI		
Mammography		
Colonoscopy		
Bone Density		
PET Scan		
Fluoroscopy		
Laboratory Services		
Lung Function Testing		
Hearing Testing		
Prenatal Scanning		
Other (specify)		
Surgical Centre:		
Eye Surgery (Cataract)		
Bariatric Surgery		
Gastric Sleeve		
Mini-Gastric Bypass		
Bariatric Revision (for complications and other issues)		
Orthopedic Surgery		
Arthroscopy		
Cosmetic & Plastic Surgery		
Podiatry Foot Surgery		
ENT & Sinus Surgery		
Vascular Surgery		
Urology Surgery		
Gynecology Surgery		
Neurosurgery (spine)		
General Surgery		
Hair Transplant		
Other (specify)		

	Relative % of Revenue	Annual # of Tests/Visits[2]
Primary Care Practice:		
Single Physician Office		
Nurse Practitioner-Led Clinic		
Group Practice		
Family Health Team		
Community Health Centre		
Walk-In Clinic		
Other (specify)		
Professional Office:		
Optometrist/ Optician		
Foot Care/Podiatry Clinic		
Rehabilitation/ Physiotherapy Clinic		
Dental Practice		
Other (specify):		
Service Provider Type:		
Staffing Agency		
Emergency Services (EMT)		
Patient Transport (non-emergency)		
Addiction Services		
Counselling Services		
Pharmacy		
In-Home Services		
Other (specify)		

Please provide a complete description of products and services offered by the Applicant. (Please attach promotional material.)

[2] Tests/Visits include diagnostic tests, scans, surgeries, patient/client visits, counselling sessions etc.

2. Does the Applicant maintain any beds for overnight occupancy (e.g., for post-operative recovery)? Yes No

   i. If yes, what is the total number of overnight beds? _______________

   ii. What is the average occupancy rate of your overnight beds? _______________

   iii. Is each overnight stay bay/room equipped with vital sign monitoring equipment? (Vital sign monitoring equipment includes fixed or portable equipment for blood pressure, oxygen saturation and temperature monitoring.) Yes No

   iv. Is there a documented call rota for anesthesia service and the surgical specialty of any overnight admission? Yes No

   v. Is the nurse staffing in the overnight stay area when there are patients receiving care in compliance with regulatory requirements (i.e., at least one RN and one RPN/LPN)? Yes No

Section 4 – Professional Liability Section

1. Does the Applicant require Medical Director coverage for both administrative duties and oversight of medical care, where applicable? Yes No N/A

   Name of Medical Director: ____

2. Does the Applicant ensure that all its physicians (surgeons, anesthesiologists, dentists, etc.) are members of a Medical Defence Organization (CMPA) or otherwise carry personal professional liability insurance? Yes No N/A

   i. As part of the practitioner credentialing process, is evidence of this coverage required on an annual basis? Yes No

3. Is there a formal mechanism for medical staff credentialing, privileging and re-credentialing that requires documentation on each physician and primary source verification of each physician's professional training and experience? Yes No N/A

4. Does the Applicant provide medical or nursing teaching facilities? Yes No N/A

   If yes, please provide details: ____

5. Staff Details:

   i. State the number of employed and contracted staff (i.e., contracted staff for the Applicant who are NOT employees) by profession and employment status:

	Employed		Contracted
Health Professional	Full-time	Part-time	
Anesthesia Assistants/Physician Assistants			
Attendants			
Audiologists			
Care Aides			
Chiropodists			
Chiropractors			
Community Health Workers			
Dental Assistants			
Dental Hygienists			

	Employed		Contracted
Health Professional	Full-time	Part-time	
Dental Technologists			
Denturists			
Dieticians			
Kinesiologists			
Medical Assistants			
Medical Laboratory Technologists			
Medical Radiation Technologists			
Midwives			
Nurse Practitioners			

5. Staff Details:

i. Employed and contracted staff (continued)

Health Professional	Employed		Contracted
	Full-time	Part-time	
Occupational Therapists			
Opticians			
Optometrists			
Osteopaths			
Paramedics			
Personal Support Workers			
Pharmacists			
Physiotherapy Assistants			
Podiatrists			
Psychological Assistants			
Psychologists			

Health Professional	Employed		Contracted
	Full-time	Part-time	
Registered Nurses			
Registered (Licensed) Practical Nurses			
Registered Psychotherapists			
Social Workers			
Speech-Language Pathologists			
Other (describe)			
Non-Health Personnel:			
Administrative			
Clerical			
Other (describe)			

ii. Medical practitioners

Medical Practitioner	Full-time	Part-time	Contracted or Employed
Anesthesiologists			
Dentists			
Family Practice Physicians			
Gynecologists			
Neurosurgeons			
Ophthalmologists			
Oral Surgeons			
Orthopedic Surgeons			
Otolaryngologists			
Pathologists			
Plastic Surgeons			
Radiologists			
Urologists			
Vascular Surgeons			
Other (describe)			

6. Do all Independent Contractors carry their own Professional Liability (Medical Malpractice) insurance? Yes No

If no, does the Applicant provide Professional Liability coverage for these individuals? Yes No

7. Are the professional licenses or certificates of all employees and independent contractors:

i. Verified prior to their employment? Yes No

ii. Verified annually? Yes No

8. Are there formal mechanisms for the selection, recruitment, orientation and performance management of all personnel? Yes No

i. Is there a written policy on the prevention of abuse (including sexual abuse) of patients? Yes No
If yes, please attach a copy of the policy.

ii. Is there written policy on the prevention and management of harassment/abuse of staff by patients? Yes No

iii. Does the Applicant have formal, written protocols/procedures for handling allegations or complaints of abuse of patients? Yes No

9. Operations:

i. Is informed consent obtained prior to all medical procedures/treatments/tests etc.? Yes No
(Please provide a copy of the informed consent form.)

ii. Do you have a documented risk management program? Yes No

iii. Do you have a formal program for clinical quality assurance? Yes No

iv. Are there formal procedures for communicating the results of diagnostic tests (e.g., laboratory tests) promptly to the physician or nurse practitioner who requested the test? Yes No N/A

v. Are there protocols in place for the management of standard, frequently encountered conditions? Yes No N/A

vi. Are there written protocols for handling complications or emergencies (e.g., anaphylaxis)? Yes No N/A
(Please provide a copy of the protocol.)

vii. Are procedures for infection prevention and control, including the sterilization of medical instruments and devices, followed and in compliance with relevant professional/regulatory guidance? Yes No N/A

viii. Do staff members receive training on all equipment they use in prior to using it? Yes No N/A

ix. Is there a preventive maintenance program for all biomedical equipment? Yes No N/A

x. Are contemporaneous clinical records made after all clinical contacts with patients, including telephone contacts? Yes No

xi. Are measures in place for the protection of patient/client health information, in compliance with relevant privacy legislation? Yes No

Section 5 – General Liability

1. Are all contractors and sub-contractors required to provide proof of liability insurance and name the Applicant as an additional insured to their insurance? Yes No

2. Are measures in place to ensure compliance with all regulatory workplace health and safety requirements? Yes No

3. Are employees advised of and updated on their rights under Employment Standards legislation? Yes No
Is a copy of the Employment Standards Act available for consultation? Yes No

4. Are all employees covered by the provincial Workers Compensation Board or equivalent? Yes No
If no, is there an alternative Employee Benefit/Disability Program? Yes No

5. Preceding termination of an employee, are progressive disciplinary actions (e.g., written warnings) performed and documented? Yes No

6. Is a lawyer consulted prior to dismissing any employee? Yes No

7. What, if any, premises functions or facilities are sub-contracted (e.g., cleaning, waste disposal)?

____

8. Do the premises have emergency back-up systems for the loss of essential utilities? Yes No

9. Are measures in place to ensure compliance with current regulations regarding the safe collection, storage and disposal of all waste, including sharps and other hazardous waste? Yes No N/A

10. Are secure medication storage facilities provided for the storage of controlled substances and narcotics? Yes No

11. Do employees drive their personal vehicles for work-related purposes? Yes No

a. If yes, do they report this to their personal automobile insurer? Yes No

b. If yes, do they carry a minimum limit of $1 million in Automobile Third-Party coverage on their personal automobile policy? Yes No

12. Are written procedures in place to comply with laws governing the handling and disclosure of patient health information? Yes No

13. Have you ever been investigated for the breach of someone's identifiable information? Yes No

If yes, please provide a detailed explanation: ____

Section 6 – Life Safety

1. Is the emergency power equipment checked weekly to ensure functionality? Yes No

2. Is there sufficient lighting at all times in all corridors to make the direction and path of travel safe? Yes No

3. Are sufficient electrical outlets available, labeled and grounded to suit the location (e.g., wet locations, cystoscopy-arthroscopy), and connected to emergency power supplies where appropriate? Yes No

4. Is an emergency power source available for life-safety-related fixtures and devices (e.g., exit lighting, life support/monitoring, alarm systems)? Yes No

5. Are all explosive and combustible materials and supplies stored and handled in a safe manner, with appropriate ventilation, according to regulatory requirements (i.e., health and safety)? Yes No N/A

6. Are compressed gas cylinders stored and handled in a safe manner, according to the relevant regulatory health and safety requirements? Yes No N/A

7. Are fire extinguishers throughout the facility/office regularly inspected and in compliance with local fire codes? Yes No

8. Are fire exit signs posted and illuminated? Yes No

9. Do staff members receive fire and emergency procedures training on hire and annually thereafter? Yes No

10. Are fire drills conducted quarterly? Yes No

Section 7 – Claims And Insurance History

1. Claims:

   i. Have any negligence claims ever been made against you, whether successful or otherwise? Yes No

   ii. Are you aware of any claim or incident that has not yet been reported to your insurance company? Yes No

   iii. Please list all claims and incidents that may result in a claim incident prior to the effective date of this proposed policy, which would have given rise to a claim from your professional activities in the past year.*

Policy Period	Insurer	# of Claims	Total Incurred

* Attach previous carrier loss runs

2. Insurance History:

   i. Have you ever been declined, cancelled or non-renewed by an insurer for Professional Liability Insurance? Yes No

   If yes, please provide details: _______________

   ii. Have you ever been cancelled or non-renewed by an insurance company? Yes No

   If yes, please provide details: _______________

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

This product will be underwritten by Continental Casualty Company, a CNA property/casualty insurance company. All products and services may not be available in all provinces or territories and may be subject to change without notice. Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and exclusions for an insured. "CNA" is a registered trademark of CNA Financial Corporation. Certain CNA Financial Corporation subsidiaries use the "CNA" trademark in connection with insurance underwriting and claims activities. Copyright © 2020 CNA. All rights reserved. 20200113 19-0239-PROD

Addendum A – Ambulatory Surgical Centres Questionnaire

1. Policies and Procedures – Pre-operative:
   - **i.** Are all ambulatory surgery patients screened to exclude high-risk patients (e.g., by ASA risk score)? Yes No
   - **ii.** Are written consent forms used for each type of procedure performed? If yes, is the surgeon also required to sign the consent form? Yes No
   - **iii.** Is the physician required to discuss the procedure and consent with the patient prior to performing the procedure? Yes No
   - **iv.** Is there written documentation of a pre-operative anesthesia evaluation, per ASA guidelines and airway assessment? Yes No
   - **v.** Is there preoperative history and physical examination in the medical record, by the day of surgery? Yes No
   - **vi.** Is there a formal process in place which includes pre-operative verification of the patient? Yes No
   - **vii.** Is there a formal process in place which includes pre-operative verification of the surgical site? Yes No
   - **viii.** Is there a formal process in place to which includes marking of the operative site? Yes No
   - **ix.** Is there a "time out" immediately before starting the procedure? Yes No
2. Policies and Procedures – Intra and post-operative:
   - **i.** Is there documentation and signing of all intra-operative orders? Yes No
   - **ii.** Is there written documentation of all medications and intravenous fluids given? Yes No
   - **iii.** Is there a written policy in place for patient positioning? Yes No
   - **iv.** Has a formal laser safety program been established? Yes No
   - **v.** Do patients receive continuous physiological monitoring? Yes No
   - **vi.** Does the OR(s) have sufficient emergency back-up power, in compliance with regulation and/or based on an assessment of environmental risks to the power source? Yes No
   - **vii.** Are all pathology and other specimens disposed of according to policy and procedure? Yes No
   - **viii.** Are sponge, needle and instrument counts performed, to confirm the count is correct? Yes No
   - **ix.** Are all surgical instruments reprocessed in accordance with provincial/territorial guidance? Yes No
   - **x.** Do staff members performing reprocessing have appropriate certifications to perform these processes? Yes No
   - **xi.** In the event of complications, are there emergency handling procedures at the facility? Yes No
   - **xii.** Is emergency equipment tested routinely, with documentation? Yes No
   - **xiii.** Are all medications for resuscitation available on the emergency cart? Yes No
   - **xiv.** Are malignant hyperthermia drugs available? Yes No
   - **xv.** Are all clinical staff CPR trained or higher? Yes No
   - **xvi.** Are mock codes performed on a regular basis? Yes No
   - **xvii.** Is there a process for the urgent transfer of a patient to an acute care facility in the event of an adverse patient outcome or deterioration of the patient's status beyond the capability of the ASC to manage? Yes No
     (Please provide a copy of the policy.)
   - **xviii.** Are professional personnel trained in emergency response present during all hours of operation? Yes No N/A
   - **xix.** Is there a formal discharge policy which requires that patients meet specific discharge criteria after receiving procedural sedation or anesthesia? Yes No
   - **xx.** Are written post-operative instructions provided to all patients? Yes No
   - **xxi.** Are patients instructed how to seek medical attention after hours, as part of the discharge instructions? Yes No
   - **xxii.** Are patients who have received procedural sedation or anesthesia required to be accompanied home by a responsible adult? Yes No
   - **xxiii.** Is there documentation and signing of all post-operative orders and timely dictation of operative notes? Yes No

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Addendum B – Diagnostic Imaging (DI) Centres Questionaire

1. Is a written requisition provided for each patient consultation? Yes No
2. Are patients informed of their appointment and the wait for service? Yes No
3. Does the DI have a documented process for prioritizing patient appointments? Yes No
4. Is a written final report containing the results of the imaging examination or procedure transmitted to the ordering physician/nurse practitioner as appropriate? Yes No
5. Is a preliminary report issued in unexpected cases where clinical urgency mandates immediate communication of the results? Yes No
6. Are patients who may have infectious respiratory infections identified on registration, offered a surgical face mask and segregated, if possible? Yes No
7. Is there a secure and private location for changing clothing and for the temporary storage of personal items available for patients? Yes No
8. Are women screened for possible pregnancy? Yes No
9. Is signage posted in patient waiting, changing and examination rooms advising women to tell staff if they are pregnant? Yes No
10. Is the DI accredited/credentialed in the areas where it is providing services (e.g. mammography)? Yes No
11. Do technologists have the specific skills and competencies to deliver the services provided by the Applicant? Yes No
12. Is lead protective equipment available in each radiation examination room? Yes No
13. Does the centre has signage and/or controls (such as a patient registration desk) to restrict patients from accessing and/or preventing entry into the diagnostic imaging area? Yes No
14. Does the Applicant have written, referenced, signed and dated procedures manual for all diagnostic imaging tests? Yes No
15. Are policies and procedures reviewed on a regular basis to ensure they are consistent with current medical, infection prevention and control, performance protocols, etc.? Yes No
16. Are routine quality control activities performed in accordance with accreditation/regulatory requirements? Yes No
17. Is the Applicant involved in any services open to the public (i.e. health fairs, shopping mall exhibits, mobile testing units)? Yes No
    If yes, attach a full description of services.
18. Is the DI technology used maintained through a service program to deliver optimal performance in order to ensure it meets the current standard(s)? Yes No
19. Are there maintenance agreements for CT, MRI and other like equipment? Yes No N/A
    If yes, is there a maintenance agreement with a third party? Yes No N/A
20. Type of imaging services provided:
    a. CONTRAST MEDIA (Complete if applicable):
        ii. Are there protocols for use of contrast media? Yes No N/A
        iii. Are patients screened for likelihood of adverse reaction to contrast media? Yes No
        iv. Is a physician present during the injection of contrast media? Yes No
        v. Is the contrast media restricted to non-ionic types? Yes No
        vi. Are there policies and procedures for responding to adverse reaction to contrast media? Yes No
        vii. Are all technicians/technologists trained in CPR? Yes No
    b. MRI SERVICES (Complete if applicable):
        i. Is access to the examination room controlled by the DI technologists? Yes No
        ii. Are patients screened for subcutaneous metals such as pacemakers and clips? Yes No
        iii. Are only non-magnetic materials and objects allowed in the examination room, including oxygen tanks and wheelchairs? Yes No

- **iv.** Is there a noise cancellation system in the magnet area? Yes No
- **vi.** Is there an oxygen monitoring system in the magnet area? Yes No
- **vii.** Are all technicians/technologists trained in CPR? Yes No

c. X-RAY/CT/PET/SPECT/NUCLEAR MEDICINE (Complete if applicable):

- **i.** Are all tests performed at the request of a physician/nurse practitioner? Yes No
  If no, at whose request are tests performed?
- **ii.** Does a physician on the Applicant's staff review all test results? Yes No
- **iii.** Does anyone on the Applicant's staff supply a diagnosis based on the interpretation of test results to a submitting physician? Yes No

d. ULTRASOUND (Complete if applicable):

- **i.** Is a chaperon provided if requested by the patient? Yes No
- **ii.** Are patients instructed to remove only the clothing that will interfere with the performance of the test? Yes No
- **iii.** Are patients provided with gowns and sheets to cover the areas where clothing was removed? Yes No
- **iv.** Does the technologist tell the patient what areas of the body will be examined and when and why she or he will be touched? Yes No
- **v.** Does the patient remove the gel at the end of the scan and not the technologist? Yes No

e. MOBILE SUPPLEMENT (Complete if applicable):

- **i.** Does the Applicant own and/or operate any mobile units? Yes No
  If yes, please answer the following:
  - What type? ____________________
  - How many units? ____________________
  - What services are performed? ____________________
  - Who manufactured the truck(s) and/or trailer(s)?____________________
  - Who installed the unit(s)? ____________________
  - Who maintains the unit(s)? ____________________ Attach a copy of the maintenance agreement(s).
  - What is the radius of mobile operations?____________________

f. EQUIPMENT MAINTENANCE (to be completed by all Applicants):

- **i.** Are records of inspection, maintenance, testing and calibration of equipment kept by the Applicant? Yes No
  Time intervals of inspections (weekly, monthly, etc.):
- **ii.** Does the Applicant adhere to manufacturer's direction for inspection and maintenance of screening/imaging equipment? Yes No
  If no, explain why: ____________________
- **iii.** Describe equipment maintenance done by:
  - Applicant's Staff:
  - Outside Technicians:

g. TELEMEDICINE/TELERADIOLOGY (Complete if applicable):

- **i.** Have imaging protocols, quality parameters and other technical factors been established? Yes No
- **ii.** Do technical standards met or exceed relevant technical standards for this service? Yes No
- **iii.** Are radiologists involved in telemedicine licensed in all provinces/territories in which they practice? Yes No

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