Healthcare

Professional Renewal Application – Healthcare Facilities[1]

Instructions

This Application and all materials shall be held in form is designed exclusively for completion by healthcare facilities – clinics, professional offices, medical centres, etc.

All questions must be fully answered and all requested and/or required attachments submitted to enable a quotation or indication to be given. However, the completion and submission of this form does bind the applicant or underwriters to enter into a contract of insurance.

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. Has the following occurred in the past 12 months or is the following planned in the next 12 months?

- **i.** Sold, discontinued or acquired any operations? ◯ Yes ◯ No
- **ii.** Added any locations or leases? ◯ Yes ◯ No
- **iii.** Added any new procedure, products or services? ◯ Yes ◯ No

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

If yes, give full details here: _____

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

_____

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

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

Section 3 – Applicant Information

6. 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.

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:

Health Professional	Employed		Contracted
	Full-time	Part-time	
Anesthesia Assistants/Physician Assistants			
Attendants			
Audiologists			
Care Aides			
Chiropodists			
Chiropractors			
Community Health Workers			
Dental Assistants			
Dental Hygienists			
Dental Technologists			
Denturists			
Dieticians			
Kinesiologists			
Medical Assistants			
Medical Laboratory Technologists			
Medical Radiation Technologists			
Midwives			
Nurse Practitioners			

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

5. Please provide an updated loss history dated within 60 days listing all incidents that may result in a claim 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.

_____

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, Title* and 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