CNA / HARDY

Allied Health

Care Facilities

Proposal Form

Some of the coverages for which this Proposal form is being submitted are claims-made. If there are questions concerning these coverages, please contact your insurance agent or broker.

Instructions

This Proposal form 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" or "0". 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 Proposal form and any separate continuation sheets must be completed, signed and dated by a principal of the business.

General Information

Named of Applicant:	
Named of Insured:	
Additional Information	
Registered Office Address	

Postcode	Country
Tel	Fax
Email	Website

Does the applicant have any additional locations? *(If yes, list all locations on a separate sheet of paper and attach to this Proposal form. For each additional location, include address, telephone number, facsimile number, contact person with title, and e-mail address.)*	Yes ○ No ○
Website Address of Facility	
Requested Effective Date	

Named Insured - Provide names and descriptions of all legal entities that are intended for coverage under the applicant's policy. Please complete all requested information in all sections.
(If more space is required, please attach a separate sheet of paper.)

Name	Description	% Owned	Date Acquired	Retroactive Date

Provide a description of the services provided at the applicant's facilities.

Physical Premises - Below, please list all buildings the applicant owns, controls or occupies.
(If more space is required, please attach a separate sheet of paper and provide the information below for each additional building.)

Address	Total Sq. Ft.	Usage/ Occupancy	No. of Stories	Type of Construction (e.g. Frame/Fire Resistant/ Brick)	Sprinkler System yes/no	Smoke Detectors yes/no	Central Alarm yes/no	Owned or Leased

In which countries is the applicant conducting business?

If the applicant provides management services, describe in detail the management services performed for others.

Identify parties having financial interests in the applicant's facilities

Does the applicant own any other business(es) not shown on this Proposal?	Yes ◯	No ◯

If yes, please explain.

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.)

	Projected Year	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	£	£	£	£	£
How many years has the applicant been in operation?					years

Within the next 12-month period, does the applicant plan to carry out any of the activities listed below?
(If yes to any question, please provide details on a separate sheet of paper.)

Obtain another operation or entity	Yes ◯	No ◯
Increase the number of employees	Yes ◯	No ◯

Expand the number of locations	Yes ◯	No ◯
Eliminate/add current services	Yes ◯	No ◯
Operate in other countries	Yes ◯	No ◯

Within the past five years, has the applicant acquired, sold, or discontinued any operations? *(If yes, please provide details on a separate sheet of paper.)*	Yes ◯	No ◯

Where does the applicant provide services for the client? (The total must equal 100%.)			
Applicant's Locations	%	Mobile Facility	%
Patient's Home	%	School	%
Care Home Facility	%	Jail/Prison	%
Hospital	%	Other	%
(If other, please explain.)			

Indicate percentage of children/adolescent patients?	

Are all services provided by a medical prescription or a doctor's order?	Yes ◯	No ◯
If no, what services do not require a medical prescription or a doctor's order?		

Applicant Characteristics (Please check all applicable boxes.)			
☐ For-Profit	☐ Not-For-Profit	☐ Governmental Entity	☐ Sole Partnership
☐ Corporation	☐ Professional Association	☐ Partnership	☐ Franchise
Other (Please describe)			

Organisational - Accreditation/Certification/Registration		
Are all services provided by a medical prescription or a doctor's order?	Yes ◯	No ◯
If yes, by whom and specific to which operations?		
Is the organisation certified?	Yes ◯	No ◯
If yes, by whom and specific to which operations?		
Is the organisation licensed?	Yes ◯	No ◯
If yes, by whom and specific to which operations?		

Is the organisation registered?	Yes ○	No ○
If yes, by whom and specific to which operations?		
Has the applicants' accreditation/certification/registration or license ever been revoked?	Yes ○	No ○
If yes, please provide details.		

Coverage Requested
(Please check all that apply.)

Medical Professional Liability		
☐ Claims-Made	Retroactive Date	
Limits of Liability	£ Each Claim	£ Aggregate
☐ Deductible OR ☐ Self-Insured Retention		
Amounts	£ Each Claim	£ Aggregate
Public Liability		
☐ Occurance	☐ Claims-Made	Retroactive Date
Limits*	£ Each Claim	£ Aggregate
☐ Deductible OR ☐ Self-Insured Retention		
Amounts	£ Each Claim	£ Aggregate

**Public liability limit cannot exceed medical professional liability limit*

Previous Medical Professional Liability Coverage

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible	☐ Deductible	☐ Deductible
	☐ Self-Insured Retention	☐ Self-Insured Retention	☐ Self-Insured Retention
	Amount £	Amount £	Amount £
Coverage Form	☐ Occurrence	☐ Occurrence	☐ Occurrence
	☐ Claims-Made	☐ Claims-Made	☐ Claims-Made
Retroactive Date			
Policy Period			
Premium	£	£	£

Previous Public Liability Coverage			
	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible	☐ Deductible	☐ Deductible
	☐ Self-Insured Retention	☐ Self-Insured Retention	☐ Self-Insured Retention
	Amount £	Amount £	Amount £
Coverage Form	☐ Occurrence	☐ Occurrence	☐ Occurrence
	☐ Claims-Made	☐ Claims-Made	☐ Claims-Made
Retroactive Date			
Policy Period			
Premium	£	£	£

Previous Excess Liability Coverage			
	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible	☐ Deductible	☐ Deductible
	☐ Self-Insured Retention	☐ Self-Insured Retention	☐ Self-Insured Retention
	Amount £	Amount £	Amount £
Coverage Form	☐ Occurrence	☐ Occurrence	☐ Occurrence
	☐ Claims-Made	☐ Claims-Made	☐ Claims-Made
Retroactive Date			
Policy Period			
Premium	£	£	£

Professional Services

Indicate all services provided by completing the information in the right column. **This information is the basis for rating the submission**. If the response includes other, provide receipts and treatments. Information given should be **projected numbers for the next 12 months. Visits** are defined as the number of patients entering the facility for health-related services per year. DO NOT tally the number of departments visited or the number of procedures or treatments performed. **"Beds"** are defined as the average number of occupied beds. **"Receipts"** are defined as gross receipts.

(Add additional information on a separate sheet of paper, if needed.)

Risk Classification	Projected # next 12 months
Outpatient Surgery Centre	# of Surgeries
Mental Health Services	# of Visits/# of Beds
Blood/Plasma Bank Services	# of Donations
Cancer Treatment Services	# of Visits
Crisis Stabilization Services	# of Visits
Dialysis Services	# of Visits
Fertility Services	# of Visits
Home Health/Durable Medical Equipment Services	# of Visits, Annual Receipts (DME)
Hospice Care Services	# of Beds
Imaging Services	Annual Receipts
Laboratory Services	Annual Receipts
Lithotripsy Services	# of Visits
Medical Administrative Services	# of Patients/# of Beds
Medical Registry/Nurse Staffing/Medical Employee Contract	# of Nurses/#of Visits
Optical Services	Annual Receipts
Patient Transport Non-Emergency	# of Transports
Pharmacy Services (Exclude retail operations.)	Annual Receipts
Rehabilitation Services	# of Beds/#of Visits
School	N/A
Sleep Centre	# of Patients/# of Beds
Student Health Services	# of Students/# of Faculty Members
Substance Abuse Services	# of Visits/# of Beds
Telemedicine	# of Patients and Type of Treatment
Urgent Care Centre	# of Visits
Weight Loss Services	# of Visits

Is the applicant involved in alternative/complementary medicine?	Yes ◯	No ◯
If yes, please explain.		

Does the applicant house patients overnight?	Yes ◯	No ◯
If yes, please explain.		

Does the applicant participate in clinical research trials?	Yes ◯	No ◯
If yes, please explain.		
Provide total number of participants in active trials		

Supervising Doctor/Doctors - Provide information regarding the medical director and each physician/surgeon providing services at applicant's facility.
(Attach additional sheets of paper if needed.)

Supervising Doctor's Name	Specialty	Type of Coverage/Limits of Indemnity	GMC Registration Number	Employee/ Contractor	Hours per Month
Doctor's Name	Specialty	Type of Coverage/Limits of Indemnity	GMC Registration Number	Employee/ Contractor	Hours per Month

Do any of the doctors named above have direct patient care responsibilities at the applicant's facilities?	Yes ◯	No ◯
If yes, what is the doctor's role in providing patient services for the applicant's facility? If yes, what is the doctor's role in providing patient services for the applicant's facility?		

Indicate the minimum professional liability insurance limits required for employed and contracted professionals		
Employed or contracted doctors	£ Each Claim	£ Aggregate
Employed or contracted doctors	£ Each Claim	£ Aggregate

Is proof of liability insurance required?	Yes ○	No ○
If no, please explain.		

Has any doctor been reported to the General Medical Council?	Yes ○	No ○
If yes, please explain.		

Does applicant desire coverage to include independent contractors?	Yes ○	No ○
If yes, please explain.		

Employees/Independent Contractors Information

Healthcare Professionals	Number/Full-time	Number/Part-time	Annual Payroll
Nurses (RCN, SRN)			
Advanced Practice Nurses/Midwives			
Surgeon Assistants			
Pharmacists House			
Officers Students			
Phlebotomists			
Therapy Aides/Assistants			
Technicians - Explain			
Technologists			
Other (Specify)			
Other (Specify)			

Hiring/Screening and Employment Procedures		
Are employees'/contractors' references contacted before hiring or placement?	Yes ○	No ○
How are references checked?	☐ Written	☐ Verbal
Are job descriptions created for all staff members?	Yes ○	No ○
Does applicant verify any pending license suspensions, revocations, or pending disciplinary actions by other facilities?	Yes ○	No ○
Are criminal background checks performed for all employees/contractors?	Yes ○	No ○
If no, please explain employee/contractor categories not listed.		
Does the applicant utilize Criminal Record Bureau checks?	Yes ○	No ○
If yes, check all that apply. ☐ Pre-Hire ☐ Current Employees ☐ Work History ☐ Education ☐ Criminal Record ☐ Driving Record ☐ Alcohol/Drug Testing		

Contractual Agreements

Does the applicant have written agreements with third parties?	Yes ○	No ○
If yes, does each agreement include the following? Mutual indemnification and hold harmless clause	Yes ○	No ○
A requirement that the other party purchases liability insurance with liability limits equal to or exceeding the applicant's limits	Yes ○	No ○
A requirement that the other party supply the applicant with a current copy of a certificate of insurance	Yes ○	No ○

Medical Equipment/Supplies Sales and Leasing Operations

Does the applicant have written agreements with third parties?	Yes ○	No ○
If yes, please explain and provide annual receipts.		

Biomedical Equipment Preventive Maintenance

Medical equipment preventive maintenance (PM) is performed by whom?	In-house technician ○ Outside vendor ○	
If provided by a vendor, does the contract for PM include a hold harmless indemnification clause?	Yes ○	No ○
Are user manuals available in-house for every piece of medical equipment?	Yes ○	No ○
Is there a formal, documented equipment recall and hazard alert program?	Yes ○	No ○

Risk Management/Quality Management/Quality Improvement		
Does the applicant utilise a formal written quality management/quality improvement plan?	Yes ○	No ○
Does the applicant utilise a formal written risk management plan?	Yes ○	No ○
Medical/patient records	☐ electronic	☐ paper
If electronic, how often are back-up procedures performed?		
If paper, where are records stored?	☐ on-site	☐ off site
Are the buildings in which paper records are stored, fully sprinklered?	Yes ○	No ○

Who has the overall responsibility for risk management and quality management/improvement?	
Name	Telephone No
Title	E-mail
How long has the designated risk manager been affiliated with the entity?	

Public Liability		
Does applicant sponsor any sporting or special events?	Yes ○	No ○
If yes please explain		
Does the applicant provide alcoholic beverages at these or other events?	Yes ○	No ○
If yes, please provide details of the events.		
Is all advertising/public relations media/website information reviewed by legal counsel?	Yes ○	No ○
Is all advertising/public relations media/website information reviewed by risk management?	Yes ○	No ○

Litigations/Claims History/Sanctions/Fines		
Has the applicant had any medical professional, public liability, or excess claims or suits brought against it in the past 5 years? *(If yes, provide details on a separate sheet of paper)*	Yes ○	No ○
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? *(If yes, please provide supplemental information on a separate sheet of paper)*	Yes ○	No ○
Has the facility/operational registration ever been suspended, revoked or voluntarily suspended?	Yes ○	No ○
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 ○
Has any company with whom the applicant has been previously affiliated, become insolvent?	Yes ○	No ○
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:

- Marketing or advertising brochures or descriptive materials provided to clients
- Most recent annual report/audited financial statement
- Claim loss runs for the past five (5) or more years for all coverages for which you are applying, in Excel format, if available
- If the applicant is a new business applicant, submit professional qualifications (i.e. resume or curriculum vitae) of each owner, partner, officer and key employee
- Most recent survey reports, licensure reports and accreditation/regulatory agency survey reports
- Quality improvement, risk management, and patient safety plans/programmes
- Policy and procedures for reporting patient accidents, incidents, or severe and unexpected patient outcomes
- Policy and procedure for annual evaluation of doctors' competence
- Sample contract reflecting applicant's requirements for indemnification and liability insurance coverages from other parties

Authorisation	
I/we declare that I/we have made a fair presentation of the risk, by disclosing all material matters which I/we know or ought to know or, failing that, by giving the Insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries in order to reveal material circumstances.	
Signature in full	Name
Date	

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED	
Agency Name and Address	Person Submitting Application
Telephone Number	E-mail
Completing and signing this Proposal form 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.	

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