CNA / HARDY

Care Home

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	

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	Requested limits £

Description of applicant's operations (Check all that apply.)

☐ Limited Company	☐ Charity	☐ Limited Liability Partnership
☐ Sole Trader	☐ Trust	☐ Public Limited Company
☐ Hospital Affiliated	☐ Partnership	☐ Limited Liability Company

Total number of facilities owned by applicant	
Date(s) of establishment	
Number of years under present applicant's ownership	
Have there been any significant changes to applicant's business operations in the last 5 years? *(If yes, provide details on a separate sheet of paper.)*	Yes ◯ No ◯

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

In the past three (3) years, has any insurance carrier cancelled or refused coverage that is similar to that now being proposed?	Yes ○	No ○
If yes, please explain.		

In the past five (5) years, has any claim/suit been made against the applicant for alleged medical professional negligence, error or mistake?	Yes ○	No ○
If yes, please explain.		

How many years has the facility been under			
Present Ownership Present Ownership	years	Present Management	years

Are all applicable registrations with regulatory bodies up to date?	Yes ○	No ○
If no, please explain.		

Subsidiaries

List all subsidiaries. *(If necessary, attach an additional list.)*

Name	Location	Description of Operations/Percentage Owned

Organisation Credentials - *(If necessary, attach an additional list.)*

Registration information

Registration	Type/Number	Expiration Date	Restrictions	Provisions
			Yes ◯ No ◯	Yes ◯ No ◯
			Yes ◯ No ◯	Yes ◯ No ◯

Association memberships	
Date of last inspection/survey	
Number of deficiencies/citations	

Was a corrective action plan accepted by the regulatory body?	Yes ◯ No ◯
How many complaints were investigated in the past three (3) years?	

Level of Care for Service Users

Select only the level(s) of care reflected in the organisation's registration.
(If the registration is not specific with respect to the type of care, select the level that best reflects the services provided by applicant.)

Level of Care	Number of Service Users	
	Inpatient	Outpatient
Sub-Acute Ventilator care, wound management, post-operative/trauma recovery, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood or plasma transfusion, central line care, tracheotomy.		N/A
Skilled Nursing Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services		N/A
Intermediate Care Administration of oral medications, assistance with activities of daily living (ADLs), preventive turning/positioning, restorative rehabilitation		N/A
Assisted Living Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves, protective environment, meals, assistance with medications, group social and spiritual activities		
Personal Care Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves, protective environment, meals, assistance with medications, group social and spiritual activities		
Independent Care		
What is the total number of dwelling units?		
What is the number of residents at full occupancy?		
Are there common dining facilities?	Yes ○	No ○
Do individual units have cooking appliances?	Yes ○	No ○
If yes, please describe.		
Is there a mechanism to account for each resident on a daily basis?	Yes ○	No ○
If yes, please describe.		
Are residents allowed to have home health care aides?	Yes ○	No ○
Are the aides contracted independently?	Yes ○	No ○
Are there registered nursing personnel on staff?	Yes ○	No ○
Home- and Community- Based Services Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic services, skilled nursing care *(Attach a description of the scope of operations and services provided by applicant.)*	Number of Visits	Receipts

Indicate the percentage of residents by age range.		
% < 30	% 65-74	% 85-94
% 31-64	% 75-84	% > 95

Supplemental Services

Does applicant's organisation provide the following? (Check all that apply.)	
Adult day care	Yes ○ No ○
Child day care	Yes ○ No ○
Swimming pool	Yes ○ No ○
Saunas and/or hot tubs	Yes ○ No ○
Exercise/weight rooms	Yes ○ No ○
Community centre	Yes ○ No ○
Restaurant that is open to the public	Yes ○ No ○

Administration

Name of administrator	Registration No.
Length of time as the administrator of this organisation?	
Overall length of time as a care home administrator?	
Does the care home administrator work full-time in this organisation?	Yes ○ No ○
Director of nursing	
Name	Registration No.
Professional credentials	RCN ○ SRN ○
Length of time as director of nursing in this organisation?	
Overall length of time as a director of nursing	
Name of medical director	
Name	Registration No.
Country	
Length of time in medical director role	
Medical specialty	
Does the medical director work full-time?	Yes ○ No ○
What percentage of residents receives their direct medical services from the medical director?	

Staffing

What is the total number of employees?	
What is the total number of nurse employees?	

Please provide the staffing information per category in the chart below.

	1st shift	2nd shift	3rd shift	4th shift
RCN				
SRN				
Personal caregiver				
Agency caregiver				

Does applicant require nurses to make professional indemnity arrangements?	Yes ◯	No ◯
Does applicant obtain and review nurses' professional indemnity arrangements?	Yes ◯	No ◯
Does applicant verify nursing registrations upon hire and annually?	Yes ◯	No ◯
Does applicant verify nursing assistant credentials upon hire and annually?	Yes ◯	No ◯
Are CRB-type checks completed for agency employees?	Yes ◯	No ◯

Does the scope of the background CRB-type checks for new employees include		
Work history	Yes ◯	No ◯
Education	Yes ◯	No ◯
Criminal record	Yes ◯	No ◯
Driving record	Yes ◯	No ◯
Alcohol drug testing	Yes ◯	No ◯

Number of doctors	
Employed	Contracted

Does applicant obtain and review doctors' professional indemnity arrangements?	Yes ◯	No ◯
Does applicant require limits of liability comparable to the facility's limits?	Yes ◯	No ◯
If no, define the differences in limits.		
Does the applicant verify each doctor's medical registration with the GMC (General Medical Council)?	Yes ◯	No ◯
Is a doctor on-site or on-call on a 24-hour basis?	Yes ◯	No ◯
Is there a formal, documented assessment process to measure staff competencies?	Yes ◯	No ◯

Does applicant conduct orientation and regularly scheduled in-service training programmes for all staff/employees to educate them regarding Health & Safety required procedures?	Yes ◯	No ◯
How are employees recruited?		
Does applicant recruit staff originating from, or who have worked, outside the United Kingdom?	Yes ◯	No ◯
If yes, please explain.		

Consultants/Independent Contractors and Services

In which countries is the applicant conducting business?

Are certificates of insurance obtained from independent contractors?	Yes ◯	No ◯
Are certificates of insurance required and reviewed annually?	Yes ◯	No ◯
If yes, are limits of liability comparable to the applicant's limits?	Yes ◯	No ◯
If no, please explain.		

Volunteers

What is the total number of volunteers?		
What is the percentage of volunteers under the age of 18?		
What are the primary recruiting sources for volunteers?		
Is there a formal screening, including CRB-type checks, and an orientation process for volunteers?	Yes ◯	No ◯
If yes, please explain.		
Are roles and responsibilities of volunteers clearly communicated to staff and volunteers?	Yes ◯	No ◯
Do volunteers assist with resident feeding?	Yes ◯	No ◯
What training is provided to volunteers?		

Risk Management		
Is there a risk management programme and plan implemented throughout the organisation?	Yes ◯	No ◯
Is there a designated risk manager?	Yes ◯	No ◯
If yes, indicate the name of the responsible individual whether they work on a full-time or part-time basis.		
If yes, how long has the individual been responsible for those functions?		
Is there an incident reporting policy including an up-to-date accident and incident book?	Yes ◯	No ◯
Who within the organisation reviews the incident reports?		
Are incidents trended and presented in a committee structure?	Yes ◯	No ◯
Is there a formal patient safety programme? Indicate whether the plan includes evaluation and reduction of exposures relating to the items below.		
Life safety	Yes ◯	No ◯
Employee safety	Yes ◯	No ◯
Hazardous materials	Yes ◯	No ◯
Environment of care	Yes ◯	No ◯
Is there a formal preventive maintenance programme?		
Is responsibility for the programme assigned to one individual?	Yes ◯	No ◯
Indicate whether the programme includes the items below.		
Evaluation of all electrical devices/equipment brought into the facility	Yes ◯	No ◯
Scheduled evaluations of equipment and devices including electrical supply?	Yes ◯	No ◯
Retention of maintenance and inspection records	Yes ◯	No ◯
Does the organization have written criteria for appropriate admission to the facility?	Yes ◯	No ◯
What security measures are used to control unauthorized entrances and exits?		
If applicable, please indicate whether nursing assessment protocols are in place to identify residents at risk for the categories below.		
Unauthorized exits (elopements)	Yes ◯	No ◯
Falls	Yes ◯	No ◯

Cognitive impairment	Yes ◯	No ◯
Unexpected weight loss/weight gain	Yes ◯	No ◯
Pressure ulcers	Yes ◯	No ◯

If applicable, please provide the data indicated below.	
Number of medication errors in the past year	
Number of falls in the past year	
Number of unauthorized exits (elopements) in the past five (5) years	
Number of facility-acquired pressure ulcers in the past year	
Please provide infection rate in the past year for facility-acquired infections	

Does the applicant provide for dispensing prescription medications?	Yes ◯	No ◯
Is there a registered pharmacist on staff?	Yes ◯	No ◯
Is the facility contracting for pharmacy services?	Yes ◯	No ◯
If yes, who is responsible for the dispensing function?		
Who is responsible for administering medications?		
Are records kept to track drug supplies and dispersal?	Yes ◯	No ◯
What is the maximum value of medications within the applicant's facility?	£	
Are narcotics or other similar medications stored within the applicant's facility?	Yes ◯	No ◯
If yes, indicate how narcotics or other similar medications are stored.		

Does the facility have advance written consent from the resident or guardian that allows medical care to be provided when necessary?	Yes ◯	No ◯

Does the facility have a written procedure for reporting resident abuse?	Yes ◯	No ◯
Who is responsible for the investigation?		
Are policies in place for the immediate suspension/termination of employees suspected of, or involved in resident abuse?	Yes ◯	No ◯

Does facility have a formal grievance procedure in place to address resident/family complaints?	Yes ◯	No ◯
If yes, please explain the process.		

Additionally Required Documents

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:

- Current valued loss reports of prior carriers
- Financial statements – last two (2) years
- Photo and facility diagram/plot plan
- Brochures and/or advertising materials
- Facility web site URL
- Curriculum vitae for administrator and director of nursing
- Organizational chart
- Copy of registration with regulatory body
- Survey reports - last two (2) years (include all statements of deficiencies and any corrective action plans)
- Nutrition, elopement prevention, fall prevention, skin/wound care, and restraint protocols and procedures, as applicable

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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