CNA / HARDY

HealthPro
UK Allied

Proposal Form

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.

Named Insured:	
Registered Office Address	

Postcode	Country
Tel	Fax
Email	Website
Requested Effective Date	

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?	

Please provide a brief business description

Please give details of your current and previous insurance

	Current Year	First Prior Year
Insurance Company		
Limits of Liability		
Excess		
Basis of Current Insurance Cover:		☐ Claims-Made ☐ Occurrence
Retroactive Date		

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. Visits 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:	
Service Classification	Projected # patient contacts in next 12 months
Primary Care (for registered patients only)	# of Visits/Contacts
Out of Hours Primary Care	# of Visits/Contacts
Walk in centre/Minor Injuries Unit	# of Visits/Contacts
GP Home Healthcare	# of Visits/Contacts
Telephone Triage/NHSD/111	# of Visits/Contacts
Prison Healthcare or Immigration Healthcare	# of Visits/Contacts
Dental Services	# of Visits/Contacts
Surgical Services (please complete Surgery Appendix)	# of Procedures
Other (please specify below)	# of Visits/Contacts
Where relevant, please indicate patient population size:	

Supervising Doctors/Dentists			
Specialty	Total Number of Registered Medical / Dental Practitioners	FTE (Employed)	FTE (Self-Employed)

Do you ensure that all registered medical/dental practitioners are either members of a medical/dental defence organisation and are fully indemnified for their own malpractice or are otherwise insured for all work undertaken on your behalf?	Yes ○ No ○
If no, please explain.	

Have any of your employed/self-employed doctors been subject to disciplinary proceedings for professional misconduct?	Yes ○	No ○
If yes, please explain.		

Healthcare Professionals	Total Number	FTE (Employed)	FTE (Self-Employed)
Nurse Practitioner (prescriptive authority)			
Nurse Practitioner (no prescriptive authority)			
Triage Nurse			
Practice Nurse			
Emergency Care Practitioner			
Phlebotomist/HCA			
Pharmacist			
Call handler			
Admin/clerical			
Therapist (Specify)			
Other (Specify)			

What 'Any One Claim' Limit of Indemnity does the applicant require?					
£1m ○	£2m ○	£2.5m ○	£5m ○	£10m ○	Other (Specify)

What Aggregate Limit of Indemnity does the applicant require?					
£1m ○	£2m ○	£2.5m ○	£5m ○	£10m ○	Other (Specify)

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, provide details 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: • Claim loss runs for the past five (5) or more years for all coverages for which you are applying, in Excel format, if available • Sample contract reflecting applicant's requirements for indemnification and liability insurance coverages from other parties
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
Position in Company	
Date	

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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For more information call +44 (0)20 7743 6800 or visit cnahardy.com. Follow us on

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