

CNA / HARDY

UK Hospital Hospitals and Health Systems

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? <i>(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.)</i>			Yes <input type="radio"/> No <input type="radio"/>
Website Address of Facility			
Requested Effective Date			

Requested Limits for Medical Professional Liability (MPL) and Public Liability (PL)

Coverage	MPL – Each Claim or Medical Incident PL – Per Occurrence	Aggregate
MLP	£	£
PL	£	£

Requested Deductible			
<input type="checkbox"/> Deductible; OR		<input type="checkbox"/> Self-Insured Retention (SIR)/Captive (Please provide relevant financial and funding documents.)	
Coverage	MPL – Each Claim or Medical Incident PL – Per Occurrence	Aggregate	Allocated Loss Adjustment Expense (ALAE) Included in the Deductible
MLP	£	£	Yes <input type="radio"/> No <input type="radio"/>
PL	£	£	Yes <input type="radio"/> No <input type="radio"/>

Requested Retroactive Date If multiple retroactive dates apply, please attach a list.		
<input type="checkbox"/> MLP	<input type="checkbox"/> PL	<input type="checkbox"/> N/A

Medical Professional Liability Information

Type of Facility		
Provide a full description of your operation.		
Please describe the percentage of funding generated from the following		
% Private Funding	% Charitable Donations	% Government Funding
Contact Person		
Name	Title	
Telephone	Facsimile	
Email		
Does this facility have any teaching affiliations?	Yes <input type="radio"/>	No <input type="radio"/>
Is the facility a teaching and/or research facility?	Yes <input type="radio"/>	No <input type="radio"/>
Does the facility have any ownership or partnership interests?	Yes <input type="radio"/>	No <input type="radio"/>
If yes to any of the above, list all parties and provide full details.		
Check any and all of the following services that applicant provides.		
<input type="checkbox"/> Burn Unit	<input type="checkbox"/> Laboratory Unit	<input type="checkbox"/> Tissue/Organ/Bone/Eye Bank
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Obstetrics	<input type="checkbox"/> Genetic Testing
<input type="checkbox"/> Fertility Clinic	<input type="checkbox"/> Elective Cosmetic	<input type="checkbox"/> Gender Reassignment
<input type="checkbox"/> Bariatric Surgery		

Exposures

(Provide annual occupancy/visit exposures for the past 12 months and the projected 12 months.)

	Past 12 Months	Projected 12 Months
Total Beds Set Up and Staffed		

Inpatient Beds - Number of Occupied Beds by Type

Acute Medical/Surgical		
Swing		
Psychiatric		
Alcohol/Chemical Abuse/Dependency		
Rehabilitation		
Intensive Care		
Care Home		
Other (Please describe)		

Annual Total Inpatient Days - Surgery Statistics

Number of Inpatient Surgeries		
Number of Endoscopies		
Number of Outpatient Surgeries (Exclude outpatient endoscopies.)		

Outpatient Visits (OPV) - Number of Annual Visits by Department/Specialty

Accident and Emergency**		
Home Healthcare*		
Psychiatric/Substance Abuse		
Rehabilitation*		
Dialysis		
Radiology/Imaging**		
Laboratory**		
Chemotherapy**		
Blood/Blood Products Transfusion Services**		
All Other Outpatient Visits		

Retail Receipts	Past 12 Months	Projected 12 Months
Pharmacy		
Non-Patient Cafeteria/Restaurant		
Gift Shop		
Durable Medical Equipment (rental)		
Durable Medical Equipment (sales)		

* If services are located in a separate facility, please complete Care Home Proposal Form.

** List exposures by patient encounters, not number of procedures.

Will any new services or construction or acquisitions be added within the next 12 months? (If yes, provide details on a separate sheet of paper.)	Yes <input type="radio"/>	No <input type="radio"/>
Have any services been discontinued within the last 12 months? (If yes, provide details on a separate sheet of paper.)	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant provide management services to other healthcare entities? (If yes, provide details on a separate sheet of paper and provide copies of contract(s).)	Yes <input type="radio"/>	No <input type="radio"/>
Is the applicant managed by a contracted entity? (If yes, provide name and address on a separate sheet of paper and provide a copy of the contract.)	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant engage in telemedicine (i.e. radiology, cardiology, ophthalmology, remote monitoring for home patients, dermatology, etc.)? (If yes, provide details on a separate sheet of paper.)	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant provide any Internet-based patient services? (If yes, provide details on a separate sheet of paper.)	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant have a business continuity plan in the event of a computer system failure, virus or malfunction? (If yes, provide a copy of the plan.)	Yes <input type="radio"/>	No <input type="radio"/>

Employed Doctors, Contracted Doctors, and Other Professional Employees
(Provide the number of Full Time Equivalents (FTEs) for each of the categories below.)

	Past 12 Months	Projected 12 Months
House Officers* (1st and 2nd Year)		
General Practice Registrars*		
Specialist Registrars*		
General Practitioners*		
Consultants*		
Fellowships*		
Dentists		
Oral Surgeons		

Podiatrists		
Nurses		
Paramedics		
Other		

**** List each employed or contracted doctor on a separate sheet of paper and include medical specialty, whether the doctor performs major or minor surgery, and medical professional liability insurance retroactive date.**

Medical Staff		
Is there a Supervising Consultant Doctor/Medical Director?	Yes <input type="radio"/>	No <input type="radio"/>
Are credentials validated for all new medical staff members?	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant validate the doctor's registration?	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant validate membership in the Royal College of Physicians or Royal College of Surgeons?	Yes <input type="radio"/>	No <input type="radio"/>
Does an identical validation process apply to mid-level providers (i.e. podiatrists)?	Yes <input type="radio"/>	No <input type="radio"/>
doctors' employees on premises (i.e. private scrubs, first assistants, etc.)?	Yes <input type="radio"/>	No <input type="radio"/>
Is there an annual appraisal of individual doctors based on the General Medical Council's Good Medical Practice?	Yes <input type="radio"/>	No <input type="radio"/>
Who is responsible to perform the annual appraisal of doctors?		
What steps are taken to address doctor incompetence?		
How are complaints or questions related to doctor competence managed?		

How are continuing medical education credits tracked, monitored, and documented and by whom?
Indicate what steps are taken for doctors who do not complete the annual continuing medical education requirements.

Has the applicant reported any doctors to the General Medical Council or other regulatory agency?		
Have any doctors had conditions attached to their registration? <i>If yes, explain in detail on separate sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>
Have any doctors received a time-limited suspension from the medical register? <i>If yes, explain in detail on separate sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>
Have any doctors been erased from the medical register? <i>If yes, explain in detail on separate sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>

Does the applicant perform drug and alcohol testing for all doctors as part of its initial credentialing/validation process?	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant perform criminal record background (CRB) checks for all doctors?	Yes <input type="radio"/>	No <input type="radio"/>
Does the applicant validate in writing that medical and dental doctors are members of a medical/dental defence organisation or are individually insured for their own medical malpractice?	Yes <input type="radio"/>	No <input type="radio"/>
What limits of insurance/indemnity are required for doctors?		
Is proof of insurance provided to the hospital annually?	Yes <input type="radio"/>	No <input type="radio"/>

Anaesthesia

Are all anaesthetists at the Consultant level?	Yes <input type="radio"/>	No <input type="radio"/>
If no, list required credentials.		
Are the Royal College of Anaesthetists' patient monitoring standards required in all areas where anaesthesia is administered (i.e. OR, OB, GI Lab, Cardiac Catheterization Lab, etc.)?	Yes <input type="radio"/>	No <input type="radio"/>
Is an anaesthetist on-site 24 hours per day, 365 days per year?	Yes <input type="radio"/>	No <input type="radio"/>
If no, state how emergency anaesthesia services are provided.		
Does an informed consent discussion take place between the patient and the anaesthetist that includes the anaesthesia contemplated, and explanations of possible risks and alternatives?	Yes <input type="radio"/>	No <input type="radio"/>
Is the informed consent discussion documented in the medical record?	Yes <input type="radio"/>	No <input type="radio"/>

Surgery

Are House Officers permitted to provide direct patient surgical services?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, indicate the services they may provide.		
Can a House Officer perform any surgery without direct supervision by a surgeon? <i>If yes, provide details on a separate sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>
Are any of the following procedures performed at the applicant's facility? <input type="checkbox"/> Experimental Surgery <input type="checkbox"/> Paediatric Surgery <input type="checkbox"/> Bariatric Surgery <input type="checkbox"/> Transplants <input type="checkbox"/> Sex Reassignment Surgery <i>If any of these are performed at your facility, provide full details on a separate sheet of paper as to the specific procedure(s) performed and the number of procedures performed on an annual basis.</i>		
Does an informed consent discussion take place between the patient and surgeon that includes possible risks, benefits and alternatives?	Yes <input type="radio"/>	No <input type="radio"/>
Are patients telephoned following discharge from outpatient surgery?	Yes <input type="radio"/>	No <input type="radio"/>

If yes, who performs the call, and is the patient's stated condition documented?			
Title of person calling			
Is patient's stated condition documented?		Yes <input type="radio"/>	No <input type="radio"/>
Accident and Emergency Department (A&E)			
Do you have an Accident and Emergency (A&E) Department?		Yes <input type="radio"/>	No <input type="radio"/>
Does the A&E Department treat and manage major trauma cases?		Yes <input type="radio"/>	No <input type="radio"/>
Are House Officers providing services in the A&E Department?		Yes <input type="radio"/>	No <input type="radio"/>
If yes, how are they supervised?			
Is there a helipad?		Yes <input type="radio"/>	No <input type="radio"/>
What are the minimum required limits of liability insurance for A&E doctors?	£ per Claim	£	Aggregate
Are all A&E doctors at the Consultant level in A&E medicine?		Yes <input type="radio"/>	No <input type="radio"/>
If no, is the supervising doctor a Consultant in A&E medicine?		Yes <input type="radio"/>	No <input type="radio"/>
If no, list required credentials.			
Is the A&E Department staffed with a doctor(s) 24 hours a day?		Yes <input type="radio"/>	No <input type="radio"/>
Do A&E doctors respond to inpatient emergencies?		Yes <input type="radio"/>	No <input type="radio"/>
Do A&E doctors write admitting orders?		Yes <input type="radio"/>	No <input type="radio"/>
Are all A&E patients examined by a doctor prior to discharge? <i>If no, provide details on a separate sheet of paper.</i>		Yes <input type="radio"/>	No <input type="radio"/>
Is there a patient triage system?		Yes <input type="radio"/>	No <input type="radio"/>
What level of staff performs triage?			
Are clinical pathways utilized for conditions such as chest pain, congestive heart failure (CHF), women with abdominal pain, children with fever, etc.?		Yes <input type="radio"/>	No <input type="radio"/>
Are all A&E support personnel certified in Advanced Cardiac Life Support (ACLS)/Paediatric Advanced Life Support (PALS)?		Yes <input type="radio"/>	No <input type="radio"/>
Are paramedics in radio contact with an A&E doctor for orders?		Yes <input type="radio"/>	No <input type="radio"/>
Do paramedics execute treatment according to approved standards and protocols?		Yes <input type="radio"/>	No <input type="radio"/>
Are A&E waiting times tracked from arrival to triage?		Yes <input type="radio"/>	No <input type="radio"/>

Are A&E waiting times tracked from triage to doctor contact?	Yes <input type="radio"/>	No <input type="radio"/>
If a patient leaves before being seen by a doctor, is there telephone follow-up with appropriate documentation?	Yes <input type="radio"/>	No <input type="radio"/>
Are there procedures for managing combative/disruptive patients/families?	Yes <input type="radio"/>	No <input type="radio"/>
How are psychiatric patients, deemed to be at risk for harming themselves or others, managed in the A&E Department?		

Radiology

Are all radiologists at the Consultant level?	Yes <input type="radio"/>	No <input type="radio"/>
If no, list required credentials.		
On a separate sheet of paper, describe the process for notifying the patient and doctor if there is a discrepancy in a radiological interpretation requiring the patient to return.		
Have there been any accidents at your facility(ies) involving the use of radiological or nuclear medicine materials? <i>If yes, provide details on a separate sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>
If mammograms are performed - What standards for quality assurance are used?		
Are Royal College of Radiology standards used?	Yes <input type="radio"/>	No <input type="radio"/>
Are invasive procedures performed by radiologists?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, list types of procedures.		
Is teleradiology utilized in reading films/images?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, describe what quality controls are utilized?		

Psychiatric (Behavioural Health) Services

Are psychiatric/substance abuse/behavioural health services provided?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, provide the following percentages of patients.		
	% Inpatients	% Outpatients
Geriatric		
Adult		
Adolescent		
Paediatric		
Other		

Are patients separated based on age, sex or other criteria? <i>Explain how patients are separated on another sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>
Are patients admitted with a primary diagnosis of substance abuse and/or alcohol and/or chemical dependency?	Yes <input type="radio"/>	No <input type="radio"/>
Are policies and procedures present to address patient security?	Yes <input type="radio"/>	No <input type="radio"/>
Are there policies and procedures related to the use of physical and/or chemical restraints?	Yes <input type="radio"/>	No <input type="radio"/>
Are elopement drills conducted?	Yes <input type="radio"/>	No <input type="radio"/>
Are all psychiatrists at the Consultant level?	Yes <input type="radio"/>	No <input type="radio"/>
If no, list required credentials.		
Is there a policy/procedure for management of medically ill psychiatric patients?	Yes <input type="radio"/>	No <input type="radio"/>
Is electroconvulsive therapy (ECT) performed?	Yes <input type="radio"/>	No <input type="radio"/>
Are policies/procedures present to address informed consent, sedation/ anaesthesia, post procedure monitoring for ECT?	Yes <input type="radio"/>	No <input type="radio"/>
Are outpatient psychiatric/behavioural health services provided? <i>If yes, provide details on a separate sheet of paper.</i>	Yes <input type="radio"/>	No <input type="radio"/>
Are services to psychiatric clients provided in group homes/care homes or other residential settings? <i>If yes, complete the CNA Care Home proposal form.</i>	Yes <input type="radio"/>	No <input type="radio"/>

Risk Management, Quality Management, and Patient Safety

Contact person for risk/quality and patient safety functions (If more than one person, list all.)

Name

Title

Telephone

Facsimile

Email

To whom does this person report?

Name

Email

Is this person responsible for any other department/service?

Yes ☐

No ☐

If yes, list all other areas of responsibility.

Please provide a copy of the following.

- Risk management/quality management/patient safety plan(s)
- Most recent annual health check by the Healthcare Commission
- Any investigations conducted by the Healthcare Commission or by any regulatory body, and documentation of corrective actions taken
- Risk manager's position description
- Copy of any form(s) used to report patient accident(s) or incident(s)

Has applicant's organisation considered obtaining Joint Commission accreditation?	Yes <input type="radio"/>	No <input type="radio"/>
Is there formal interface between quality management and risk management?	Yes <input type="radio"/>	No <input type="radio"/>
Is information on patient safety, risk, and quality management reported to the hospital board on a regular basis?	Yes <input type="radio"/>	No <input type="radio"/>
Does the hospital measure patient satisfaction?	Yes <input type="radio"/>	No <input type="radio"/>
Describe the method of measurement.		
Does the hospital have complaint resolution policies and procedures?	Yes <input type="radio"/>	No <input type="radio"/>
Are incident reports tracked and trended with summarized incident data reported to the hospital board on a regular basis?	Yes <input type="radio"/>	No <input type="radio"/>
Check the responsibilities that apply to the function of the risk/quality/safety department.		
Health Information Management	Emergency Preparedness	Infection Control
Claim Management	Contract Review	Insurance Purchasing
Corporate Compliance	Quality Management	Safety
Regulatory Compliance	Litigation Management	Other
List all accreditations/surveys.		

Human Resources

Does pre-employment screening include a criminal record background (CRB) check, drug screen and reference verification?	Yes <input type="radio"/>	No <input type="radio"/>
If no, please explain.		
Are job descriptions, orientation programs and performance appraisals job-specific and competency-based?	Yes <input type="radio"/>	No <input type="radio"/>
If no, please explain.		
Are agency/temporary personnel used?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, is orientation provided and documented?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, are proof of criminal record background check reports and drug test results obtained or verified as being on file with the agency?	Yes <input type="radio"/>	No <input type="radio"/>
What is the total number of employees?		
Full-Time	Part-Time	Total

Public Liability

On a separate sheet of paper, list all locations indicating square footage, number of floors, construction materials, and fire protection used.

Helipad

Does the applicant own or lease an aircraft?
If yes, provide details on a separate sheet of paper.

Yes ☐ No ☐

Does the applicant have a helipad or heliport?
If yes, please provide responses to the following:

Yes ☐ No ☐

Are there re-fuelling capabilities?

Yes ☐ No ☐

How many landings occur per year?

Does the hospital contract with an air flight service?

Yes ☐ No ☐

Does the hospital annually verify liability insurance with air flight vendor?

Yes ☐ No ☐

If independent contractors are used, does the hospital require that they carry insurance?

Yes ☐ No ☐

If yes, what limits of liability are required?

£ Per Claim £ Aggregate

Current Liability Coverage

Complete the following chart.

	MPL	PL	Excess	Other (Please specify.)	Other (Please specify.)
Carrier					
Policy Period					
Limits of Liability	£	£	£	£	£
Are ALAE included in the Limits of Liability?	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
Deductible/SIR	£	£	£	£	£
Claims-Made or Occurrence	CM <input type="radio"/> Occ <input type="radio"/>	CM <input type="radio"/> Occ <input type="radio"/>	CM <input type="radio"/> Occ <input type="radio"/>	CM <input type="radio"/> Occ <input type="radio"/>	CM <input type="radio"/> Occ <input type="radio"/>
Expiring Premium	£	£	£	£	£

Has any insurance carrier cancelled, refused or non-renewed applicant's previous liability insurance?

If yes, provide full details on a separate sheet of paper.

Yes ☐ No ☐

Additional Materials

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
- Professional qualifications (i.e. resume or curriculum vitae) of each owner, partner, officer and key employee, if the applicant is new business
- 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 procedures for annual evaluation of doctors' competence
- Sample contract reflecting hospital'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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For more information call +44 (0)20 7743 6800 or visit cnahardy.com. Follow us on

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