CNA HEALTHPRO
ANCILLARY PERSONNEL APPLICATION
CLAIMS-MADE COVERAGE

I PERSONAL/PROFESSIONAL DATA

Name (last, first, middle, designator)				Date of birth
Clinic name				
Primary practice address	City	State	Zip Code	County
Residence address	City	State	Zip Code	County
Telephone - office	Fax number		Telephone - residence	
Number of years at current office location	If less than three years, list previous locations and class			
Tax I.D. number		Social Security number		
Additional practice locations				

PLEASE ATTACH A COPY OF YOUR CURRENT POLICY DECLARATIONS PAGE AND BUSINESS LETTERHEAD

Desired policy dates

Effective date: ______________________

Prior Acts date: ______________________

Desired coverages/limits

☐ Professional liability __________ each claim/ __________ aggregate

☐ Personal umbrella (not available in all states)

Check the one that applies:

☐ H/L perfusionist ☐ Nurse anesthetist ☐ Nurse midwife ☐ Nurse practitioner O/R technician

☐ Paramedic ☐ Physician assistant ☐ Scrub nurse ☐ Surgeon assistant

COMPANY/AGENCY USE ONLY

Territory	Dec ISO	PLD Code	Policy number	Group	Producer Number
Step	Rate ISO	Rate Class	Account number	Producer's name	

II MEDICAL TRAINING AND HISTORY

Please answer all questions completely. If a question does not apply to you, mark "N/A" or "0."
Do not leave any questions unanswered. If space is inadequate, use the Comments section or attach a separate sheet.

1. Medical education

	Institution	State	Degree/Certification	From	To	Date graduated
A.						
B.						
C.						

D. Number of hours continuing medical education completed in the past two years: ________ hrs.

2. Type of certification/license you currently hold (specify license numbers): ________

3. Has your license or certification ever been voluntarily or involuntarily suspended, denied, revoked or restricted in any state? ☐ No ☐ Yes — Explain: ________

4. Date and location you began practicing: ________ ________

5. Do you have any medically related duties that are insured by another company or for which you do not desire CNA coverage? ☐ No ☐ Yes — Explain: ________

6. Number of hours worked for this physician/corporation/partnership per week: ________

7. Do you work for anyone other than this physician/corporation/partnership? ☐ No ☐ Yes — Explain: ________

8. Do you ever work in an operating room? ☐ No ☐ Yes — If so, do you ☐ observe ☐ assist ☐ other ________

9. Do you ever work in an emergency room? ☐ No ☐ Yes

10. Brief description of your duties: ________

11. To what extent are you supervised, and by whom? ________

12. Are you under contract in any capacity involving the practice of medicine? ☐ No ☐ Yes — Explain: ________

13. Are you a member of any medical associations/societies? ☐ No ☐ Yes — Please state which ones: ________

14. Have any fee, professional relations or other complaints been registered against you with any medical association, hospital or state licensing authority? ☐ No ☐ Yes — Explain: ________

II MEDICAL TRAINING AND HISTORY (continued)

15. Have you ever been diagnosed with or treated for alcoholism, drug addiction, or mental or physical impairment?

16. Have you ever been charged with any criminal activity? ☐ No ☐ Yes — Please state which ones: ____________

III INSURANCE HISTORY

17. Carrier information

	Current carrier	First prior carrier	Second prior carrier
Insurance company			
Policy number			
Coverage form	☐ Claims-made ☐ Occurrence	☐ Claims-made ☐ Occurrence	☐ Claims-made ☐ Occurrence
Policy period			
Limit of liability per claim/aggregate			
Prior Acts date			

18. Have you ever been insured by CNA for professional liability? ☐ No ☐ Yes — List policy number or name of previous employer: ____________

19. Do you maintain separate coverage for professional liability? ☐ No ☐ Yes

20. Has your insurance for medical malpractice ever been canceled, suspended, non-renewed or declined?
☐ No ☐ Yes — Explain: ____________

V CLAIM HISTORY

21. Has any claim or suit for alleged malpractice ever been brought against the clinic or any ancillary personnel or are you aware of any circumstances that might lead to such a claim or suit?
☐ No ☐ Yes — Complete the following claims questionnaire. If you need more space, use comments section or attach an additional sheet

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

____

____

☐ Claim open.	Amount paid on your behalf
☐ Claim closed.	Amount reserved on your behalf?

V CLAIM HISTORY (continued)

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

____

____

☐ Claim open.	Amount paid on your behalf
☐ Claim closed.	Amount reserved on your behalf?

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

____

____

☐ Claim open.	Amount paid on your behalf
☐ Claim closed.	Amount reserved on your behalf?

COMMENTS SECTION)

____

____

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

***For FL, KY, MN, NJ, NY, OH and OA residents only*: Any person who knowingly and with intent to defraud any Insurance Company or other person who files an Application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. *For NY residents only*: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claim for each such violation.**

______________________________ ______________________________

Signature in Full **Date**

____

Name - Please print

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

This program is underwritten by and Application is made to CNA. CNA is a registered service mark of the CNA Financial Corporation.