CNA HEALTHPRO
MEDICAL PRACTITIONERS APPLICATION
CLAIMS-MADE COVERAGE

I PERSONAL/PROFESSIONAL DATA

Name (last, first, middle, designator)				Date of birth (MM/DD/YY)
Clinic name/Employer				
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 dates			
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)

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 specialty: _____ Percentage of practice: _____ **%**

Sub-specialty: _____ Percentage of practice: _____ **%**

2. Medical education

A. Medical school: Institution		State	From	To	Completed? ☐ No ☐ Yes
B. Internship: Institution		State	From	To	Completed? ☐ No ☐ Yes
C. Residency: Institution	Specialty	State	From	To	Completed? ☐ No ☐ Yes
D. Residency: Institution	Specialty	State	From	To	Completed? ☐ No ☐ Yes
E. Fellowship: Institution	Specialty	State	From	To	Completed? ☐ No ☐ Yes

3. If you are a graduate of a foreign medical school:
- are you certified by the Education Council for Foreign Medical Graduates? ☐ No ☐ Yes
- have you passed the FLEX? ☐ No ☐ Yes

4. Number of hours continuing education completed within the past two years: _____ hrs.

5. Date and location you began practicing: _____ (Date) _____ (City,State)

6. Medical license information

State	License number	Expiration date	Status

7. Narcotics/DEA license number: _____ Status: _____

8. Board certification information

Name of board: _____ ☐ Certified ☐ Qualified

Name of board: _____ ☐ Certified ☐ Qualified

Name of board: _____ ☐ Certified ☐ Qualified

II MEDICAL TRAINING AND HISTORY (continued)

9. List the corresponding medical associations/societies of which you are a member:

A. County: _____

B. State: _____

C. National: _____

10. Has your board certification or membership in any medical association/society ever been voluntarily or involuntarily suspended, denied, revoked or restricted in any state?

☐ No ☐ Yes — Explain: _____

11. Has your medical or narcotics license ever been voluntarily or involuntarily suspended, denied, revoked or restricted in any location?

☐ No ☐ Yes — Explain: _____

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

☐ No ☐ Yes — Explain: _____

13. Have any fee, professional relations or other complaints been registered against you with any medical association, state licensing authority or hospital?

☐ No ☐ Yes — Explain: _____

14. Have you ever been charged with any criminal activity?

☐ No ☐ Yes — Explain: _____

15. Has any claim or suit for alleged sexual misconduct ever been brought against you?

☐ No ☐ Yes — Explain: _____

16. Have Medicare or Medicaid authorities ever brought charges against you?

☐ No ☐ Yes — Explain: _____

III INSURANCE HISTORY

1. Carrier information

	Current carrier	First prior carrier	Second prior carrier
Insurance company			
Coverage form	☐ Claims-made ☐ Occurrence	☐ Claims-made ☐ Occurrence	☐ Claims-made ☐ Occurrence
Policy period			
Limit of liability per claim/aggregate			
Deductible or S.I.R. and amount	☐ Deductible ☐ S.I.R. $	☐ Deductible ☐ S.I.R. $	☐ Deductible ☐ S.I.R. $
Prior Acts date			

III INSURANCE HISTORY (continued)

2. Has your insurance for medical malpractice ever been canceled, suspended, non-renewed or declined?

☐ No ☐ Yes — Explain: _____

3. Have you ever had professional liability insurance provided by CNA? ☐ No ☐ Yes

4. If you are currently insured by a claims-made policy:

A. Are you obtaining Extended Reporting ("tail") coverage from your current insurance company? ☐ No ☐ Yes

B. Is Prior Acts coverage being requested? ☐ No ☐ Yes

If Yes, show Prior Acts effective date: _____

and **attach a copy of your most recent policy declarations page**.

C. Has your practice changed significantly in the last five years?

☐ No ☐ Yes — Explain: _____

Note: To prevent possible gaps in your claims-made coverage, either Extended Reporting or Prior Acts coverage must be purchased.

IV CURRENT MEDICAL PRACTICE

1. Do you practice medicine on a part-time (20 hours or less per week) basis? ☐ No ☐ Yes

2. Percentage of your practice outside of your primary state? _____ %

List States: _____

3. Percentage of your practice devoted to practicing as a locum tenens: _____ %

4. Type of practice: (Check all that apply.)

☐ Solo Practitioner

☐ Partnership Name: _____

☐ Group Name: _____

☐ Employee Of: _____

☐ Space sharing With: _____

☐ Independent contractor For: _____

5. Do you supervise residents? ☐ No ☐ Yes If yes, how many? _____

6. 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: _____

7.

Check all with which you are associated:	Name	Percentage of Practice	Relationship
☐ Solo Practitioner			
☐ Governmental body			
☐ Military service			
☐ Educational institution			
☐ Professional sports team			
☐ Clinic with inpatient facilities			
☐ Urgent care center			
☐ Commercial laboratory			
☐ Administrative position			
☐ Surgicenter			
☐ Office with surgical suite			
☐ Nursing home or long term care facility			

IV CURRENT MEDICAL PRACTICE (continued)

8. Are you under contract (other than PPO, HMO, IPA or anything listed in Question 7) in any capacity involving the practice of medicine?

☐ No ☐ Yes — Explain: _____

9. Do you have hospital privileges? ☐ No* ☐ Yes

Hospital Name	City, County, State	Type of privilege	
		☐ Full ☐ Restricted	☐ Courtesy ☐ Other*
		☐ Full ☐ Restricted	☐ Courtesy ☐ Other*
		☐ Full ☐ Restricted	☐ Courtesy ☐ Other*

*** If No, Restricted or Other, please explain on your letterhead.**

10. Have your hospital privileges ever been suspended, denied, revoked, restricted or otherwise sanctioned?

☐ No ☐ Yes — Explain: _____

11. Do you work in the emergency department other than to fulfill requirements for you hospital privileges?

☐ No ☐ Yes — List number of hours per week: _____

12. Do you perform or assist in any surgical procedure in a non-hospital setting during which general anesthesia is administered?

☐ No ☐ Yes — Complete the following:

A. Do you follow ASA standards for preoperative monitoring? ☐ No ☐ Yes

B. Number of procedures annually: _____ Description: _____

C. Anesthesia administered by: _____

13. Do you perform surgery (see categories - these lists may not be all inclusive)?

No Surgery — perform neither surgery nor obstetrical procedures. Incising of boils and superficial fascia, suturing or minor lacerations, removal of superficial skin lesions by other than surgical excision and assisting in surgery are not considered surgery. ☐ No ☐ Yes

Minor Surgery — applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following medical techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive), tonsillectomies, and adenoidectomies. ☐ No ☐ Yes

Please list types of procedures routinely performed: _____

Major Surgery — includes operations in or upon any body cavity including, but not limited to, the carnium, throax, abdomen, pelvis or any other operation which because of the condition of the patient or length of the circumstances of the operation presents a distance hazard to life. It also includes: removal of tumors, open bone fractures, amputations, termination of pregnancy, the removal of any gland or organ (excluding tonsillectomies and adenoidectomies), plastic surgery and any operation done using general anesthesia. ☐ No ☐ Yes

_____ number per year

Please list types of procedures routinely performed: _____

IV CURRENT MEDICAL PRACTICE (continued)

14. Please answer the following. If you answer yes to any question with asterisks(**), please explain fully on your letterhead.

Average number of patients seen per week: _____

Do you perform the following procedures?

A.	Elective cosmetic surgery	☐ No ☐ Yes —	percentage of practice: _____ %
B.	Itinerant surgery	☐ No ☐ Yes **	
C.	Vaginal deliveries	☐ No ☐ Yes —	number per year: _____
D.	Cesarean sections	☐ No ☐ Yes —	number per year: _____
E.	Deliveries outside the hospital	☐ No ☐ Yes **	
F.	Abortions	☐ No ☐ Yes —	percentage of practice: _____ %
G.	Neonatology	☐ No ☐ Yes —	percentage of practice: _____ %
H.	Professional sports medicine	☐ No ☐ Yes **	
I.	Angiography/arteriography/ cardiac catheterization	☐ No ☐ Yes	
J.	Experimental procedures	☐ No ☐ Yes **	
K.	Weight control surgery/drugs	☐ No ☐ Yes **	percentage of practice: _____ %

L. If you are a primary care physician, do you automatically receive the results of tests and consultation/exam reports ordered by the physician/surgeon to whom your patient was referred?

☐ No
☐ Yes — How quickly do receive them?

V CLAIMS HISTORY

Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?

☐ No ☐ Yes — Complete the following. If you need more space, use the comments section or attach an additional sheet.

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

Allegations

_____

_____

_____

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

V CLAIMS HISTORY (continued)

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

Allegations

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

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

Allegations

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

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

Allegations

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

COMMENTS SECTION

Question number	Comments

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 PA 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 one of the CNA Insurance Companies. CNA is a registered service mark of the CNA Financial Corporation.