Healthcare
Application Form

US

The purpose of this application form is for us to find out more about you. You must provide us with all information which may be material to the cover you wish to purchase and which may influence our decision whether to insure you, what cover we offer you or the premium we charge you.

How to complete this form

The individual who completes this application form should be a senior member of staff at the company and should ensure that they have checked with other senior managers and colleagues responsible for arranging the insurance that the questions are answered accurately and as completely as possible. Once completed, please return this form to your insurance broker.

Section 1: Company Details

1.1 Please state the name and address of the principal company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form.

Company name:

Primary address (Address, State, ZIP, Country):

Website:

Date the business was established (MM/DD/YYYY):

Number of employees: Employee Reference No. (ERN):

1.2 Please state your gross revenue in respect of the following years:

	Last complete financial year	Estimate for current financial year	Estimate for next financial year
Domestic revenue:	$	$	$
International revenue:	$	$	$
Total gross revenue:	$	$	$
Profit (Loss):	$	$	$

Date of company financial year end (MM/DD/YYYY):

1.3 Please list names, location and descriptions of all legal entities, including subsidaries which this application is in respect of:

Section 2: Activities

2.1 Please provide a percentage breakdown of the services provided:

2.2 Please indicate the estimated number of patient encounters for the next 12 months:

2.3 Please confirm if the applicant maintains any beds for overnight stays: ☐ Yes ☐ No

2.4 Please state whether all professionals are subject to the following background checks: ☐ Yes ☐ No

a) Criminal and sexual offender registry checks: ☐ Yes ☐ No

b) Credentialing and verifying of professional certificate of licenses of all employees and independent contractors: ☐ Yes ☐ No

2.5 Please state whether any doctor or provider has had a board action brought against them in the last 5 years: ☐ Yes ☐ No

If "yes", please provide further details:

2.6 Please state whether any medications are prescribed as a part of your services: ☐ Yes ☐ No

If "yes", please provide some details on what medications are being prescribed and confirm if there are any controlled substances:

2.7 Please provide a breakdown of your staff by numbers:

	Employed	Contracted
Aesthetician:		
Certified nursing assistant (CNA):		
Counsellor:		
Dental assistant/hygientist:		
Dietician / Coach:		
Fitness trainer:		
Home healthcare aide:		
Licensed Practical Nurse (LPN):		
Live-in companion:		
Masseuse:		
Medical assistant:		
Medical director:		
Medical technician:		
Nurse practitioner:		
Nursing administrator:		
Nutritionist:		
Optician:		
Optometrist:		
Pharmacist:		
Phlebotomist:		
Physical, Occupational and Speech therapist:		
Physicians assistant:		
Chiropractor:		
Psychiatrist		
Registered nurse:		
Social worker:		
Other: Please specify:		

2.8 Please confirm if the following carry their own Professional Liability insurance policies:

a) Employees: ☐ Yes ☐ No

b) Placed Personnel: ☐ Yes ☐ No

c) Physicians: ☐ Yes ☐ No

d) Sub-contractors: ☐ Yes ☐ No

If you have answered "yes" to any of the above, please confirm the limits of their respective Professional Liability insurance policies:

2.9 Please confirm if you sell any products: ☐ Yes ☐ No

If yes, please provide full details:

2.10 Please confirm whether minors are always supervised by a parent or guardian: ☐ Yes ☐ No

Section 3: Cyber Security Risk Management (tick if no cover is required ☐)

3.1 Please describe the type of sensitive information you hold and provide an approximate number of the unique records that you a) store, b) process, c) access:

3.2 Please confirm the maximum number of records (PII/PHI) that someone could access at any one time:

3.3 Please describe the most valuable data assets you store:

3.4 Please confirm whether multifactor authentication is used on all remote access and email accounts: ☐ Yes ☐ No

If yes, please confirm whether full disk encryption is used as standard: ☐ Yes ☐ No

3.5 Please confirm how sensitive data is stored from point of collection to being at rest.

3.6 Please state:

a) who is responsible for IT security within your business (by job title):

b) how many years have they been in this position:

c) whether you comply with any internationally recognised standards for information governance: ☐ Yes ☐ No

If you have answered yes to c. above, please state the internationally recognised standards with which you comply:

Section 4: Coverage History

4.1 Please provide details of any professional liability coverage purchased in the last five (5) years to date:

Policy period	Primary/ XS Limit	Deductible	Carrier	Annual Premium	Occurance or Claims Made	Retroactive Date

4.2 Please provide details of any general liability coverage purchased in the last five (5) years to date:

Policy period	Primary/ XS Limit	Deductible	Carrier	Annual Premium	Occurance or Claims Made	Retroactive Date

Section 5: Claims Experience

5.1 Have you ever been declined or refused coverage, or had coverage cancelled or non-renewed: ☐ Yes ☐ No

5.2 Please state whether you are aware

a. which may result in a claim under any of the insurance for which you are applying to purchase in this application form: ☐ Yes ☐ No

b. which resulted in legal action being made against any of the companies to be insured within the last 5 years: ☐ Yes ☐ No

c. which has resulted in cease and desist orders been made against you: ☐ Yes ☐ No

d. which resulted in a partner or director being found guilty of any criminal, dishonest or fraudulent activity or being investigated by any regulatory body: ☐ Yes ☐ No

If you have answered "yes" to any of the above then please describe the incident, including the monetary amount of the potential claim or the monetary amount of any claim paid or reserved for payment by you or by an insurer. Please include all relevant dates, including a description of the status of any current claim which has been made but has not been settled or otherwise resolved:

Important Notice

By signing this form you agree that the information provided is both accurate and complete and that you have made all reasonable attempts to ensure this is the case by asking the appropriate people within your business. CFC Underwriting will use this information solely for the purposes of providing insurance services and may share your data with third parties in order to do this. We may also use anonymized elements of your data for the analysis of industry trends and to provide benchmarking data. For full details on our privacy policy please visit www.cfcunderwriting.com/privacy

Contact name: Position:

Signature: Date (MM/DD/YYYY):