CNA

CNA HEALTHPRO
PROVIDER QUESTIONNAIRE
CLAIMS-MADE COVERAGE

In order for you to be considered for coverage, please complete this questionnaire in full and submit along with required attachments and/or supplementary information as requested. Additional information may be required upon review by the Company. If you need additional space to properly respond to a question, please write "*see attached*" and respond via separate attachment. Please be sure to sign and date this questionnaire.

➢ **The following required attachments must be submitted along with this completed SIGNED AND DATED questionnaire.**

- ☐ Copy of current Insurance Policy Declarations Page IF coverage for prior acts is requested.
- ☐ Up-to-date Curriculum Vitae/Resume and copy of all active state Medical and Narcotics/DEA License(s).
- ☐ Formal, up-to-date loss runs from all prior insurance companies for the past 5 years. A ***CLAIM / INCIDENT / SUIT SUPPLEMENT*** form must be completed for each claim, incident and/or suit.

PERSONAL/PROFESSIONAL DATA

Name (last, first, middle,): Have you ever practiced under a name other than as it appears on your medical license? ☐ No ☐ Yes If "Yes" – details?_____	Date of Birth (MM/DD/YY) Illinois Medical License Number
Medical Specialty:	Designation ☐ MD ☐ DO ☐ NP ☐ PA ☐ OTHER:_____

Primary Practice Address:	City	State	Zip Code	County

Residence Address:	City	State	Zip Code	County

Email Address:	Telephone:	Fax Number:

Desired coverage effective date: _____ **Desired prior acts date:** _____

MEDICAL PRACTICE, TRAINING AND LICENSE HISTORY

Please answer all questions completely. If a question does not apply to you, mark "N/A" or "0."

1. Number of hours continuing education completed within the past two years: _____ hrs.
2. Percentage of your practice outside of your primary state? _____ % List States:_____
3. Average number of patients seen per week: _____ Average number of hours worked per week: _____

4. **In regard to your Medical/DEA License:**
   - **a.** Has any State/Medical Board ever refused you a medical license? ☐ No ☐ Yes
   - **b.** Has any State/Medical Board ever restricted, suspended or revoked your medical license? ☐ No ☐ Yes
   - **c.** Has any State/Medical Board ever imposed a fine or any other obligation? ☐ No ☐ Yes
   - **d.** Has any State/Medical Board ever issued a letter of guidance? ☐ No ☐ Yes
   - **e.** Has any State/Medical Board ever placed you on probation or restricted your practice? ☐ No ☐ Yes
   - **f.** Is your medical license currently under investigation for any reason? ☐ No ☐ Yes
   - **g.** Has your Narcotics/DEA license ever been surrendered/refused/suspended/revoked, voluntarily or otherwise? ☐ No ☐ Yes

   IF YES to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents:

5. **Have you ever** been evaluated, treated or recommended for treatment of alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ☐ No ☐ Yes
   IF YES, describe circumstances, outcome, dates, and attach copies of any relevant documents:

6. **Have you ever** been diagnosed with, or treated for, a chronic physical illness and/or disability? ☐ No ☐ Yes
IF YES, provide complete details including dates and attach copies of any relevant documents:

_____

7. **Have you ever** been charged with or convicted of a felony or misdemeanor (other than a minor traffic violation)? ☐ No ☐ Yes
IF YES, describe circumstances, outcome, dates, and attach any relevant documents:

_____

8. Have your hospital privileges ever been suspended, denied, revoked, restricted or otherwise sanctioned? ☐ No ☐ Yes
IF YES, explain:_____

INSURANCE HISTORY

9. Has your insurance for medical malpractice ever been canceled, suspended, non-renewed or declined? ☐ No ☐ Yes
IF YES, please explain:_____

CLAIMS HISTORY

a. **Has any claim or suit for alleged malpractice ever been brought/filed against you or are you presently involved in malpractice litigation either directly or indirectly?** ☐ **No** ☐ **Yes**

IF YES, how many:_____ Complete a Claim / Incident / Suit Supplement Form for **each**.

b. **Have all circumstances / incidents which you feel might reasonably lead to a claim or suit, even if you have not been made aware of possible litigation and/or believe the circumstance would be without merit, been reported to your present or past insurance carrier(s)? Please select the appropriate response from below:**

☐ **N/A** ↔ A response of "**N/A**" means that you are not aware of any circumstances / incidents which might reasonably lead to a claim or suit being brought against you.

☐ **Yes** ↔ **IF YES:** i. How many such circumstances / incidents are there? _____ Complete Supplemental for each

☐ **No** ↔ **IF No:** i. How many such circumstances / incidents are there? _____ Complete Supplemental for each

AUTHORIZATION

I have answered the questions in the Questionnaire 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 Questionnaire does not bind the Insurance Company to complete the insurance, but it is agreed that this Questionnaire will form the basis of the contract should coverage be issued.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to $15,000.) (For Colorado, Tennessee and Virginia Residents only: Penalties may include imprisonment, fines, denial of insurance benefits and civil damages.)

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.

_____ _____
Signature Date

_____
Name – Please Print

WUPI Insurance Application—Appendix

The items listed below are documents needed on each physician for WUPI coverage:

1. Completion of C.N.A. application
2. Five-year claims history (If the physician has been insured through Washington University for the previous 5 years, the Risk Management Office will provide the 5-year claims history.)
3. Current CV
4. Current temporary or active Illinois license and DEA
5. Completion of course of MedRisk and Expert Witness Affirmation (both are accessed via Learn@Work).

Forward the completed application and attachments to Regina Swink swinkr@wustl.edu in the Risk Management Office.