



CNA HEALTHCARE AGING SERVICES
SUPPLEMENTAL APPLICATION

This application must be completed and signed by the applicant. Please include with the application.

- ACORD Applications
- Signed Statement of Values
- Aging Services Business Interruption Worksheet (if applicable)
- Current valued loss reports of prior carriers (5 years minimum)
- Most recent FYE balance sheet and income statement
- Brochures and/or advertising materials
- Resident Admission Agreement
- Expiring Policy
- Resumes for Administrator & Director of Nursing (DON)
- Copy of facility license
- State survey reports - last two (2) years (Include all statements of deficiencies and Corrective Action Plans)
- Substantiated Complaint Survey(s) and Corrective Action Plans if complaint is within the last two (2) years
- Organizational chart including corporate structure
- Emergency Evacuation Plan

Corporate/Parent Information

Corporate/Parent Name: _____ For-Profit Individual
 Corporate Address: _____ Not-for-Profit Partnership
 City: _____ State: _____ Zip: _____ Religious Affiliation Corporation
 Hospital Affiliated

Total number of facilities owned: _____ (if more than one, provide list of owned/managed facilities insured separately)

Are there any plans for new construction, mergers, acquisitions, sale of assets or business during the next 12 months?
 Yes No

Applicant/Facility Information

Facility Name: _____ Website Address: _____
 Facility Address: _____ Federal Employer ID #: _____
 City: _____ State: _____ Zip: _____ Provider ID: _____

Year ownership acquired the facility: _____

Is Facility Managed by 3rd Party Management Company: Yes No

If the answer to above is "Yes", please provide name of Management Company: _____

Year Management Company Started: _____

Facility Licensure Information

Has any facility had its license suspended, revoked or placed on probation in the last five (5) years? Yes No

Has Medicare or Medicaid Certification been revoked or suspended in the last five (5) years? Yes No

Has any facility been the subject of federal/state fines, sanctions or civil monetary penalty against it or any of its staff?
 Yes No

If the answer to any of the above questions is "Yes", please provide details on separate attachment.

Do any facilities participate in a State Compensation Fund (IN, KS, LA, PA)? Yes No



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Prior Carrier and Claims History

Prior Carrier: _____

Occurrence

Effective Date: _____

Claims-Made

Expiring Premium: _____

Claims-Made Retro Date: _____

Missouri Applicants – Please do not answer the following two questions.

In the past three (3) years, has any insurance carrier cancelled, non-renewed or refused coverage? Yes No

If the answer above is “Yes,” please indicate reason for cancellation, non-renewal or restriction.

Carrier withdrawal from state or line of business

Misrepresentation or fraud by Applicant

Carrier insolvency

Applicant filed suit against carrier

Claims frequency and/or severity

Other _____

Claims History and Prior Known Incidents

Has any claim, suit or regulatory proceeding been made against the Applicant, or any facility proposed for coverage, at any time during the past three (3) years? Yes No

Is the Applicant or any facility proposed for coverage aware of any fact, circumstance, incident or loss which has occurred after the proposed retroactive date, which is not yet a claim but is likely to result in a claim that would be subject to the coverage requested? Yes No

This includes but is not limited to (please select all that apply):

- Death of a client, patient or resident other than natural causes Yes No
- Incident resulting in hospitalization or transfer of a client, patient or resident Yes No
- Injury to a client, patient or resident that required medical care Yes No
- Incident that generated a formal complaint or notice from a state, federal or licensing agency Yes No
- Elopement or unauthorized escape or absence of a client, patient or resident Yes No
- Complications from improper medication or improper dosage Yes No
- Request for medical records or other information related to a client, patient or resident Yes No

If the answer to any of the above is “Yes”, please provide details on separate attachment.

Did the liability policies from the applicant’s prior insurance carrier(s) specify that a claim will be considered to have been made when the earlier notice of an occurrence or incident was first provided to the insurer? Yes No

Are all resident related incident reports reviewed by the DON and Administrator? Yes No

Are incidents trended and presented to the quality/risk management committee & board of trustees? Yes No



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Classification

Resident Services	Licensure	Occupancy
Sub-Acute	Total Licensed Beds:	Average Occupancy:
Skilled Care	Total Licensed Beds:	Average Occupancy:
Intermediate Care	Total Licensed Beds:	Average Occupancy:
Assisted Living	Total Licensed Beds:	Average Occupancy:
Memory Care	Total Licensed Beds:	Average Occupancy:
Personal Care	Total Licensed Beds:	Average Occupancy:
Independent Living	Total # of Units:	Average Occupancy:
Post-Acute Care	Total Licensed Beds:	Average Occupancy:

Please indicate the percentage of residents by age range (100%): ___ <18 ___ 18-55 ___ 56-75 ___ >75

Are facilities approved for Medicare? Yes No If "Yes", please indicate the number of beds: _____
 Are facilities approved for Medicaid? Yes No If "Yes", please indicate the number of beds: _____
 Private Pay Yes No If "Yes", please indicate the number of beds: _____

If facilities are multi-story buildings, are the non-ambulatory residents on the lower floors (1st or 2nd)? Yes No

Do any facilities operate as a managed care provider? Yes No



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Non-Resident Services	Client Information	Revenue
Home Health Care (Social)	Total Annual Visits:	Annual Revenue:
Home Health Care (Medical)	Total Annual Visits:	Annual Revenue:
Adult Day Care (Social)	Total Number Licensed:	Annual Revenue:
Adult Day Care (Medical)	Total Number Licensed:	Annual Revenue:
Hospice	Annual Number of Clients:	Annual Revenue:
Meals on Wheels	Annual Number of Meals:	
Pharmacy Yes No	Open to Public Yes No	Annual Revenue:
Child Day Care Yes No	Open to the Public Yes No Average Attendance:	Annual Revenue:
PACE (Program of All-Inclusive Care for the Elderly) Yes No	If "Yes", please complete a PACE supplemental application	Annual Revenue:

Are any of the above Non-Resident services provided by independent contractors? Yes No

Additional Exposure	Open to the Public	Rating Basis
Pool Yes No	Yes No	#
Hot Tub/Saunas Yes No	Yes No	#
Community Centers Yes No	Yes No	Sq. Footage:
Indoor Parking Yes No	Yes No	Number of Spaces:
Restaurants Yes No	Yes No	Total Revenue:
Tennis/Racquetball Courts Yes No	Yes No	#
Exercise/Weight Room Yes No	Yes No	#

of Residents by age

of Residents by age

Behavioral Health	< 65	> 65	Behavioral Health	< 65	> 65
Addiction Issues			Bipolar Disorder		
Post-Traumatic Stress Disorder			Developmental Disabilities		
Schizophrenia			Methadone Maintenance		
Traumatic Brain Injury			Criminal Justice Referred		

Do all facilities have a formalized behavioral health program provided by outside mental health expert(s)? Yes No

Do all facilities have a formalized behavioral health program provided by in-house resources? Yes No

Do all facilities have a formalized behavioral health program? Yes No

Are Behavioral Health Residents separate from the rest of the population at all facilities? Yes No



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Nursing Services Rendered/Activities of Daily Living Services (ADL's) Rendered

Indicate the number of current residents who receive the following types of **Nursing Services**:

Classification	# of Residents
Catheter care:	
Ostomy care:	
Diabetes Care (including insulin injections):	
Medication injections:	
Medication administration:	
Enemas or suppositories:	
Continence care:	
Wound Care:	
Anticoagulation monitoring:	
On-Premises Dialysis Care:	
Ventilator Patient Care:	
Chemical Dependency Treatment:	
Mobility (ambulating, transferring to wheelchairs, etc.):	
Bowel and Bladder Management:	

Risk Assessments

Are nursing assessment protocols in place and completed according to state/federal regulations to identify residents at risk for:

Elopement	Yes	No	Nutritional Deficiency	Yes	No
Falls	Yes	No	Skin Integrity	Yes	No
Cognitive Impairment	Yes	No			

Are Risk Assessments done prior to admission of residents?	Yes	No	
How often are residents monitored during the first 72 hours after admissions?	Hourly	Daily	As Needed
Are admission, discharge and transfer criteria established?	Yes	No	

Resident Privacy/Confidentiality

Do facilities have a policy/procedure in place for confidentiality of resident health information to address the following?		
Communication to third parties	Yes	No
Access and/or display of resident information (computer screens, whiteboards, information posted on resident doors)	Yes	No
Record storage practices to ensure the integrity against fire, water damage, unauthorized access, loss	Yes	No



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Administration

Name of Administrator: _____ License Number: _____ State: _____

Year started as Administrator: _____ Year started at this facility: _____

Full time at this facility Yes No

Name of Director of Nursing (DON): _____ Professional credentials: RN LPN

Year started as DON: _____ Year started at this facility: _____

Staffing

Category	1 st Shift				2 nd Shift				3 rd Shift			
	SNF	ALF	MC	ILF	SNF	ALF	MC	ILF	SNF	ALF	MC	ILF
RN												
LPN/LVN												
CNA												
Agency												
Pool												

Do facilities maintain the same staffing levels on each shift on weekends/holidays as weekdays? Yes No

If the answer to above is "No", please provide details: _____

Total Number of Employees: _____

Total employee turnover for prior 12 months is _____%

Are background checks performed on all staff for the following items?

Licensure type and status	Yes	No	National Criminal Records	Yes	No
Work history and education	Yes	No	Driving records/MVRs	Yes	No

Do you verify nursing licenses upon hire and annually? Yes No

Is there a formal, documented assessment process to measure staff competency skills? Yes No

Are regularly scheduled in-service education programs available for all staff/employees? Yes No

Volunteers

What is the total number of volunteers? _____

Is there a formal screening and orientation process for volunteers? Yes No

Are background checks performed on volunteers? Yes No



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Medical Director

Name of Medical Director: _____ **License Number:** _____ **State:** _____

Medical Specialty: _____ **Employee** **Independent Contractor**

Year started as Medical Director: _____ **Year started at this facility:** _____

Employees/Consultants/Independent Contractors and Services

Services	Provided		Contract in Place?		Certificates of Insurance on file		Insurance Limits	Non-Resident Revenue
	Yes	No	Yes	No	Yes	No		
Physicians	Yes	No	Yes	No	Yes	No		
Nursing	Yes	No	Yes	No	Yes	No		
Wound Care	Yes	No	Yes	No	Yes	No		
Pharmaceutical	Yes	No	Yes	No	Yes	No		
Physical Therapy	Yes	No	Yes	No	Yes	No		
Occupational Therapy	Yes	No	Yes	No	Yes	No		
Speech Therapy	Yes	No	Yes	No	Yes	No		
Dietary	Yes	No	Yes	No	Yes	No		
X-Ray	Yes	No	Yes	No	Yes	No		
Medical Records	Yes	No	Yes	No	Yes	No		
Laboratory	Yes	No	Yes	No	Yes	No		
Social Services	Yes	No	Yes	No	Yes	No		
Transport/Ridesharing	Yes	No	Yes	No	Yes	No		
Barber/Beautician	Yes	No	Yes	No	Yes	No		
Food	Yes	No	Yes	No	Yes	No		
Laundry	Yes	No	Yes	No	Yes	No		
Other:	Yes	No	Yes	No	Yes	No		

Are facilities included as an Additional Insured on these policies? **Yes** **No**



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Resident Abuse/Sexual Abuse and Molestation Questionnaire

Do all employees and volunteers undergo a comprehensive background check including the following?

Social Security Number	Yes	No	Present and Previous Work History	Yes	No
Residency Information	Yes	No	State/County Criminal Search	Yes	No

Does resident assessment include cross check of National Sex Offender Registry prior to admission? Yes No

Do facilities have a written Resident Abuse and Sexual Abuse Policy? Yes No

Do facilities have a Resident Abuse and Sexual Abuse Policy that is reviewed annually with each employee/volunteer? Yes No

Do facilities have a Resident Abuse and Sexual Abuse Policy that trains employees and volunteers on the following?

Identifying Resident Abuse and Sexual Abuse	Yes	No
Reporting Resident Abuse and Sexual Abuse	Yes	No

Do facilities have a Resident Abuse and Sexual Abuse policy that includes reporting and investigating procedures that require contacting local or state authorities? Yes No

Do facilities have a Resident Abuse and Sexual Abuse policy that requires notification of appropriate family member of alleged instance of resident or sexual abuse? Yes No

Do facilities have a Resident Abuse and Sexual Abuse policy that requires the immediate suspension/termination of employees or volunteers suspected or involved in resident abuse? Yes No

Is the Applicant or any proposed insured for coverage aware of any fact, circumstance, incident or loss related to **Resident Abuse or Sexual Abuse** which has occurred in the past five (5) years which is not yet a claim but is likely to result in a claim that would be subject to the coverage requested? Yes No

If the answer to the above is "Yes", please provide details on separate attachment.



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Risk Management

Is there a risk management program implemented throughout all facilities? Yes No

Is there a designated risk manager? Yes No

Name: _____ Is it their primary role? Yes No

Is there a formal safety program which includes evaluation and reduction of exposures relating to the following?

Life safety Yes No Hazardous materials Yes No

Employees/Service Provider Yes No Environment Yes No

Is there a formal preventive maintenance program that includes the following?

Retention of maintenance and inspection records Yes No

Scheduled evaluations of equipment and devices including electrical supply Yes No

Are exits control released for residents and alarmed to central security desk or nurses station? Yes No

Is an electronic monitoring device used as part of elopement prevention practices? Yes No

If the above question is answered "Yes", is it maintained according to manufacturer's specifications? Yes No

Number of elopements in past three (3) years: _____

Is a monthly review of drug regimens performed? Yes No

Is there an automatic medication dispensing system in place? Yes No

Do facilities have a formal grievance procedure in place to address resident/family complaints? Yes No

Additional Property/Life Safety Information

Type of construction: _____ Year Constructed: _____ # of Floors: _____

Was the building originally constructed for current occupancy levels? Yes No

If "No", please explain: _____

Have there been any water damage incidents in the past five (5) years? Yes No

If "Yes", have they been corrected? Yes No

Is the operation equipped with a back-up generator? Yes No

Is the generator equipped to power the entire facility/campus? Yes No

If "No", please list areas equipped to power up: _____

Are there other occupancies in the building not related to resident care? Yes No

If "Yes", describe: _____

Is there a facility "no smoking" policy in effect, and is it being properly enforced? Yes No

Are smoking residents supervised in a designated area Yes No

Are all facilities/campuses protected (100%) throughout, including attic spaces, by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented? Yes No



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Are hardwire smoke detectors in resident rooms/apartments?	Yes	No
Are all alarm signals monitored by a UL-approved central station or the responding fire department?	Yes	No
Are fire/evacuation drills conducted?	At Least Monthly	At Least four (4) Times per Year
Does the fire department have pre-planned emergency procedures at this location?	Yes	No
In cooking areas (other than independent living units), is there a fire suppression system?	Yes	No
Is there a hood and grease filter?	Yes	No

Additional Exposures

Do any facilities have a woodworking shop on site?	Yes	No
Do any facilities participate in Clinical Trials?	Yes	No
Do any facilities provide Flu Shots to Non-Residents?	Yes	No
Do any facilities own watercraft larger than 25 feet?	Yes	No

Please List Special Events with dates that take place at or on behalf of any facilities (fundraisers, large events, etc.).

Infection Control

Do all facilities follow the CDC recommendations for infection control?	Yes	No
Do all facilities provide and document staff training for infection control?	Yes	No
Do all facilities have adequate supplies, such as Personal Protective Equipment, gloves, gowns to support the infection control program?	Yes	No
Do all facilities have a dedicated infection control nurse that monitors the program conducts surveillance and tracks the organisms?	Yes	No
Do all facilities have a qualified Infection Preventionist overseeing the facility infection control program?	Yes	No
Have any facilities been cited for the Tags 334, 441, 880, 881, 882, 883, 945 on CMS surveys within the past three (3) years?	Yes	No

If "Yes", please identify the facility and date of citation and include a copy of the plan of correction (or paste in the space below) for each:

Have any facilities had an outbreak of Norovirus, Scabies, Influenza, etc. within the past three (3) years? Yes No

If "Yes", please identify the location and the date of such outbreak.



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WARRANTY: 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 ISSUE AN INSURANCE POLICY, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID MY COVERAGE IF A POLICY IS ISSUED.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE:

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 District of Columbia residents only:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.) **(For Florida residents only:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) **(For Kansas residents only:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.) **(For Louisiana residents only:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) **(For Maine residents only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.) **(For Maryland residents only:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) **(For New Jersey Residents Only:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.) **(For New York residents only:** 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) **(For Oklahoma residents only:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) **(For Oregon residents only:** 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, may have committed a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) **(For Pennsylvania residents only:** 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 information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.) **(For Puerto Rico residents only:** Any person who knowingly and with the intention of defrauding, presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction, shall be sanctioned for each violation with a fine of not less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established imprisonment may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.) **(For Rhode Island residents only:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **(For Tennessee residents only:** 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. Penalties include imprisonment, fines and denial of insurance benefits.) **(For Vermont residents only:** 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 may be a crime and may be subject to civil fines and criminal penalties.) **(For Virginia residents only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.) **(For Washington residents only:** 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. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.) **(For West Virginia residents only:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.)



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A signature from the Applicant can be obtained electronically or as a “wet” signature prior to quote or binding.

If the Applicant decides to submit its signature electronically, the Applicant must check the “Accept” button below. By doing so the Applicant hereby consents and agrees that its use of a key pad, mouse or other device to check the “Accept” button constitutes its “signature”, acceptance and agreement as if actually signed by the Applicant in writing and has the same force and effect as a signature affixed by hand. Further, the Applicant agrees the lack of a certification authority or other third party verification will not in any way affect the validity or enforceability of its signature of any resulting contract. After checking the “Accept” button the Applicant must type in the name of the person completing this application, including the Applicant’s title and the date signed.

If the Applicant decides to submit a “wet” signature, the Applicant must sign, and add the title and date to the Application prior to quoting or binding.

SIGNATURE

Accept

Name

Title

Date

An insurance agent is required to transact your business with CNA.

Is your agency Retail OR Wholesale

Agency Name

Address

Individual Agent Submitting Application

E-Mail Address

Phone

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