



**CNA HealthPro LONG TERM CARE
NEW BUSINESS SUPPLEMENTAL APPLICATION**

II. Applicant/Facility Information

7. Facility Name: _____
 Facility Address: _____
 City: _____ State: _____ Zip Code: _____
 Federal Employer ID #: _____ Provider ID #: _____
 Contact Name: _____ Telephone: (____) ____ - ____
 Email Address: _____ Fax: (____) ____ - ____
8. In the past three (3) years, has any insurance carrier cancelled or refused coverage that is similar to the coverage being applied for here? Yes No
 If "Yes," explain: _____
9. In the past five (5) years, has any claim or suit been made against you for alleged medical professional malpractice, error or mistake? Yes No
 If "Yes," explain. Attach list with comments.
10. How many years has the facility been under: Present ownership? _____ Present management? _____
11. Are all applicable permits up to date? Yes No
 If "No," explain: _____

III. Subsidiaries

12. List all subsidiaries. Additional list attached? Yes No

Name	Location	Description of Operations

IV. Facility Credentials

13. List facility information below:
- a. License and Accreditation Information:
- | | Type/Number | Expiration Date | Restrictions? | Provisions? |
|----------|-------------|-----------------|--|--|
| License: | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| License: | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- b. Association memberships: _____
- c. Date of last inspection/survey: ____/____/____
- d. Number of deficiencies: Total: _____ D, E, F, G deficiencies: _____ F, H, I, J, K, L deficiencies: _____
- e. Was a Corrective Action Plan accepted by the State? Yes No
- f. How many complaints were investigated in the past three (3) years? _____
 How many complaints were substantiated? _____
- g. Is facility approved for Medicare? Yes No If "Yes," # of beds: _____
 Is facility approved for Medicaid? Yes No If "Yes," # of beds: _____



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V. Classification

14. **Select only the level of care reflected in the facility license.** If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.
Please indicate total licensed beds (If Independent Care, skip to “Independent Care” section).

Sub Acute:	<p>Ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis</p> <p align="right">Total Licensed Beds: _____ Average Occupancy: _____</p>
Skilled Nursing:	<p>Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer’s care and services</p> <p align="right">Total Licensed Beds: _____ Average Occupancy: _____</p>
Intermediate Care:	<p>Administration of oral medications, assistance with Activities of Daily Living (ADLs), preventive turning/positioning, restorative rehabilitation</p> <p align="right">Total Licensed Beds: _____ Average Occupancy: _____</p>
Assisted Living:	<p>Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc.</p> <p align="right">Total Licensed Beds: _____ Average Occupancy: _____</p>
Personal Care:	<p>Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc.</p> <p align="right">Total Licensed Beds: _____ Average Occupancy: _____</p>
Independent Care:	<p>Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises.</p> <p>a. What is the total numbers of units? _____</p> <p>b. What is the total numbers of residents at full occupancy? _____</p> <p>c. Are there common dining facilities? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>d. Do individual units have cooking appliances (excluding microwaves)? <input type="checkbox"/>Yes <input type="checkbox"/>No If “Yes,” check type: <input type="checkbox"/>Gas <input type="checkbox"/>Electric</p> <p>e. Is there a daily mechanism to keep track of residents? <input type="checkbox"/>Yes <input type="checkbox"/>No If “Yes,” explain procedure: _____</p> <p>f. Are residents allowed to have home health care aides?</p> <p>g. Are the aides contracted independently? <input type="checkbox"/>Yes <input type="checkbox"/>No Through facility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>h. Are there licensed nursing personnel on staff? <input type="checkbox"/>Yes <input type="checkbox"/>No What hours are they available? _____ What services do they provide? _____</p>
Home and Community Based Services:	<p>Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic services, skilled nursing care</p> <p>Number of visits: _____ Receipts: _____ Attach a description of operations.</p>



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Adult Day Care:	<input type="checkbox"/> Social (80911)	Total Participants: _____
	<input type="checkbox"/> Enhanced (Mentally Challenged) (80912)	Total Participants: _____
	<p>Social – Services include but not limited to recreational activities (crafts, music, games, shopping trips), intergenerational programs, promotion of wellness and socialization programs, educational programs</p> <p>Medical – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision, medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, Physical Therapy (PT), speech and Occupational Therapy (OT). Provided service includes service for the mentally challenged, cognitively impaired, developmentally disabled, and chronically ill.</p>	

15. Show the percentage of residents by age range:

_____ < 30 _____ = 30-64 _____ = 65-74 _____ = 75-84 _____ = 85-94 _____ >94

16. If any residents are under 64, please explain: _____

17. Additional general liability exposures.

a. Swimming Pools

- (i) Is there a swimming pool? (80901) Yes No
- (ii) Is it open to the public? Yes No
- (iii) Is the pool locked when not in use? Yes No
- (iv) Is the pool fenced? Yes No
- (v) Is a full-time lifeguard on duty? Yes No
- (vi) Is there a diving board/sliding board? Yes No
- (v) Are there depth markings? Yes No
- (vi) Is there a daily maintenance procedure in place? Yes No

b. Are there other bodies of water present? Yes No

If "Yes," describe: _____

c. Are there saunas and/or hot tubs? (80902) Yes No

If "Yes," how many? _____

Is there an attendant on duty? Yes No

If "Yes," how many hours per day is the attendant on duty? _____

d. Are there tennis/racquetball/handball courts? (80903) Yes No

If "Yes," how many? _____

e. Are there exercise/weight rooms? (80904)

If "Yes," how many: _____

Is there an attendant on duty? Yes No

If "Yes," how many hours per day is the attendant on duty? _____

Are there treadmills? Yes No

f. Are there indoor parking facilities? (80910) Yes No

If "Yes," how many parking spaces: _____

g. Is there a Community Center? (80922) Yes No

If "Yes," how many square feet in area: _____

h. Is the facility used for activities other than by residents? Yes No

If "Yes," describe: _____

i. Is the restaurant open to the public? Yes No

Gross receipts: \$_____



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Is liquor served?

Yes No



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VI. Administrator

18. Name of Administrator: _____ License Number: _____ State: _____
19. Length of time at this facility: _____ Length of time as Nursing Home Administrator (NHA): _____
 Full time at this facility? Yes No Number of hours at this facility per week? _____

VII. Nurse Staffing

20. Director of Nursing (DON):
 Name: _____ Professional credentials: RN LPN
 Length of time at this facility: _____ Length of time as DON: _____

21. a. Total # of nurse employees: _____
 b. By category:

Category	1 st shift	2 nd shift	3 rd shift	Turnover %
RN				%
LPN/LVN				%
CNA/Personal Caregiver				%
Agency				%
Pool				%

- c. Do you require nurses to carry malpractice coverage? Yes No
 d. Do you obtain and review nurses' certificates of malpractice insurance? Yes No
 e. Do you verify nursing licenses upon hire and annually? Yes No
 f. Do you verify nursing assistant certification upon hire and annually? Yes No
 g. Are background checks completed for agency and pool employees? Yes No

VIII. Physicians and Medical Director

22. Number of physicians: Employed: _____ Affiliated: _____ Contracted: _____
23. Do you obtain and review physicians' certificates of malpractice insurance? Yes No
24. Do you require limits of liability comparable to your own? Yes No
 If "No," define the differences in limits: _____
25. a. Are the physicians credentialed? Yes No
 b. Do credentialing activities include
 (i) Verification of current professional license? Yes No
 (ii) Verification of current DEA license? Yes No
26. Name of Medical Director: _____ License Number: _____ State: _____
 License Number: _____ State: _____
27. Length of time as Medical Director: _____ Medical Specialty: _____
 Full-time at this facility Part-time at this facility Number of hours at this facility per week: _____
28. Does the Medical Director also act as the attending physician to any residents? Yes No
 If "Yes," how many: _____



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29. Is there an evaluation of the Medical Director's performance? Yes No
If "Yes," define: _____
30. Is the Medical Director:
- a. involved in credentialing facility medical staff? Yes No
 - b. an active participant in the facility quality improvement program? Yes No
 - c. involved with peer review of physicians? Yes No
31. Is a physician on site or on call on a 24-hour basis? Yes No

IX. Staff/Employee Selection and Hiring

32. Is there a formal, documented assessment process to measure staff competency skills? Yes No
33. Do you conduct an orientation and regularly scheduled in-service education programs for all staff/employees? Yes No
34. How are employees recruited? _____
35. Describe background verification checks on new employees:
- a. work history? Yes No
 - b. education? Yes No
 - c. criminal record? Yes No
 - d. driving record - Motor Vehicle Record (MVR) when appropriate? Yes No
 - e. drug testing? Yes No

X. Non-Resident Services

36. Please indicate the annual number of visits or clients for the following
- Home Health Care** Yes No # of Home Health Care visits or clients per year: _____
Is home health care provided by independent contractors? Yes No
Describe home health care services: _____
- Adult Day Care** Total Licensed #: _____ Average Occupancy: _____ Hours of Operation: _____
Is this a licensed adult day care center? Yes No # of Employees: _____
Do you provide transportation to and from your facility? Yes No
Do you provide transportation to and from events? Yes No
Is a physical examination performed by a physician prior to admission? Yes No
If "Yes," describe: _____
Are medical services provided? Yes No
If "Yes," describe: _____
- Children Day Care** Total Licensed #) _____ Average Occupancy: _____ Hours of Operation: _____
of employees: _____ # of children: _____ # of employees' children: _____
Do you provide any transportation for children? Yes No
If "Yes," describe: _____
- Respite Care:** Yes No If "Yes," # per year: _____
- Hospice Care** (80931): Yes No If "Yes," # per year: _____



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Rehabilitation Services:

Yes No

If "Yes," # per year: _____

Describe in-house rehabilitation services: _____



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37. Do you provide the following services?

Service	Provided?	# of Residents	Service	Provided?	# of Residents
IV Infusion Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Developmentally Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ventilation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alzheimer's/Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		Chemical Dependency Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	

38. Do you provide any other services to your residents or the community? Yes No

If "Yes," describe: _____

XI. Consultants/Independent Contractors and Services

39. Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3) limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of Liability
Physicians	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dietary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Medical Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Social Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Recreational Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Barber/Beautician	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

40. Have certificates of insurance been obtained from independent contractors? Yes No

Are these reviewed annually? Yes No

If "Yes," are limits of liability the same as your limits of liability? Yes No

If "No," explain: _____



XII. Volunteers

41. a. What is the total number of volunteers? _____
b. What are the primary sources for volunteers? _____
c. Is there a formal screening and orientation process for volunteers? Yes No
Explain: _____
d. Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? Yes No
e. Do volunteers assist with resident feeding? Yes No

XIII. Risk Management

42. Is there a risk management program implemented throughout this facility? Yes No
43. Is there a designated risk manager? Yes No
If "Yes," indicate risk manager's name: _____
How long has the risk manager been in that position? _____
44. a. Is there an "incident reporting" policy? Yes No
b. Are all incident reports reviewed by the risk manager and medical director? Yes No
c. Are incidents trended and presented to the quality/risk management committee? Yes No
45. a. Is there a formal safety program? Yes No
b. Does it include evaluation and reduction of exposures relating to:
(i) Life safety? Yes No
(ii) Employees? Yes No
(iii) Hazardous materials? Yes No
(iv) Environment? Yes No
46. a. Is there a formal preventive maintenance program? Yes No
b. Is responsibility for the program assigned to one individual? Yes No
c. Does the program include:
(i) Evaluation of all electrical devices/equipment brought into the facility? Yes No
(ii) Scheduled evaluations of equipment and devices including electrical supply? Yes No
(iii) Retention of maintenance and inspection records? Yes No
47. What security measures are used to control unauthorized entrances and exits from the facility?

48. a. Are WanderGuards or similar devices used as part of elopement prevention practices? Yes No
If "Yes," provide type: _____
b. Are WanderGuard devices for residents and building maintained and inspected according to manufacturer's specifications? Yes No
c. Number of elopements in past three years: _____
49. Are nursing assessment protocols in place to identify residents at risk for:
a. Elopement? Yes No
b. Falls? Yes No
c. Cognitive Impairment? Yes No
d. Nutritional Deficiency? Yes No



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50. Are monthly review of drug regimens performed? Yes No
If "Yes," by whom? _____
51. a. How are medications stored? Distributed? _____
b. Are records kept on drug supplies and dispersal? Yes No
c. What is the maximum value of medications on hand? \$_____ Type: _____
52. a. Is a licensed pharmacist on staff? Yes No
b. Is an outside pharmacy used? Yes No
53. Does facility have a dedicated special unit? Yes No
If "Yes," describe type and indicate number of beds: _____
54. a. Are admission, discharge and transfer criteria established? Yes No
b. Who ensures compliance with these established criteria? _____
55. Does facility have advance written consent from resident or guardian that allows medical care to be provided when necessary? Yes No
56. a. Does facility have a written procedure for reporting resident abuse? Yes No
b. Who is responsible for the investigation? _____
c. Are policies in place for the immediate suspension/termination of employees suspected of or involved in resident abuse? Yes No
57. Does facility have a formal grievance procedure in place to address resident/family complaints? Yes No
If "Yes," explain the process: _____

XIV. Additional Property/Life Safety Information

58. Construction

- a. Type of construction: _____ Year built: _____ # of floors: _____ # of elevators: _____
- b. Date of inspection: Electrical: _____ Plumbing: _____ HVAC: _____
- c. Was the building constructed for this occupancy? Yes No
If "No," please explain: _____
- d. Have there been any water damage incidents in the past five (5) years? Yes No
If "Yes," have they been corrected? Yes No
If "Yes," describe: _____
- e. Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-enclosing doors and wall structures having a minimum 1-hour fire rating? Yes No
If "No," please explain: _____
- f. Type of wiring (copper or aluminum): _____ Type of roof: _____
Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____
- g. Has your building ever sustained foundation damage? Yes No
If "Yes," describe: _____
- h. (i) Is there a scheduled service to clean heating and ventilation ducts? Yes No
(ii) How often are ducts cleaned? _____

59. Occupancy

- a. Are there other occupancies in the building not related to resident care? Yes No
If "Yes," describe: _____
- b. Is there a facility "no smoking" policy in effect? Yes No



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c. Are smoking materials (including matches and lighters) restricted from a resident's room? Yes No



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- d. Are smoking residents supervised and/or in designated areas? Yes No
- e. How many exits (other than front doorway) are there? _____
- f. Are these equipped with panic alarms? Yes No
- g. Do alarms ring into central security desk or nurses station? Yes No
- h. Are there at least two remote exits on each floor? Yes No

60. Protection

- a. Is risk protected (100%) throughout by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented? Yes No
If not 100%, please advise which areas are not protected: _____
If not tested, please explain: _____
- b. Are all alarm signals monitored by a UL-approved central station or the responding fire department? Yes No
- c. Is there a written emergency plan covering fire, natural disasters and threats: Yes No
If "Yes," do employees receive instruction training regarding this plan? Yes No
- d. Has the fire department pre-planned emergency procedures at this location: Yes No
If "Yes," indicate the last date when these procedures were update: _____
- e. When was facility last inspected by local fire authorities: _____
- f. Is there a bulk medical gas distribution system piped in the building? Yes No
If "Yes," are emergency shutoffs provided? Yes No
If "No," is there storage of individual tanks? Yes No
If "Yes," are these tanks on rolling carts? Yes No
Are they properly chained? Yes No
- g. In cooking areas (other than independent living units), is there a fire suppression system? Yes No
 - (i) Is there a hood and grease filter? Yes No
 - (ii) What is the frequency of cleaning (i.e. monthly/quarterly)? _____
 - (iii) Do you use an outside contractor for cleaning? Yes No
 - (iv) Is the area equipped with an automatic fuel shutoff? Yes No
- h. Are hardwire smoke detectors in resident rooms/apartments? Yes No
- i. Are doors equipped with approved self-closing devices where required? Yes No
- j. Total # of fire extinguishers: _____
- k. Who is the sprinkler manufacturer and what type of sprinkler heads are used? _____
- l. If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? Yes No
- m. Are corridors, doors, ramps, stairs, etc. free and clear of obstructions? Yes No
- n. Is video surveillance used? Yes No
If "Yes," describe extent of use: _____
- o. Are fire drills conducted regularly? Yes No
If "Yes," describe: _____
- p. Are emergency call buttons in each room/unit? Yes No
- q. Are intercoms or bells provided in each resident room? Yes No
- r. Are handrails provided in hallways and bathrooms? Yes No
- s. Are bathtubs/showers equipped with non-slip surfaces? Yes No

61. Exposure

- a. How many miles is the facility located from the coast? _____ miles
- b. Is risk located in a federally classified earthquake zone? Yes No
If "Yes," what zone? _____
- c. Is risk located on a fault? Yes No
- d. Is risk in a flood zone? Yes No



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If "Yes," what zone? _____



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XV. Commercial Automobile

62. Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents? Yes No
 If "Yes," what is the name of the transport service? _____
 Contact Name: _____ Telephone Number: () - _____
63. Do employees transport residents in their own automobiles? Yes No
 If "Yes," describe: _____ Average frequency: _____
64. Do you require them to carry minimum insurance limits? Yes No
 If "Yes," what limits are required? \$ _____
65. a. Do you have any Commercial Driver's License vehicles? Yes No
 b. If "Yes," how many: _____
66. Do volunteers operate any vehicles? Yes No
67. Are driving records reviewed annually? Yes No

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 PROTECTION SHOULD A POLICY BE 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 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 Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Print : Applicant Name & Title

Authorized Signature of Applicant

Date

Application is made to CNA member property-casualty companies. This program is not available outside the United States. CNA is a registered service mark and trade name of CNA Financial Corporation.