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Medical Malpractice

Corporate Health Providers Proposal Form

General Guidance

Insurance is a contract of the utmost good faith. This means that the information you provide in this Proposal Form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your proposal for insurance. If you have any doubt over whether something is relevant, please let us have details.

This Proposal Form is for a “claims made” policy. A “claims made” policy only responds to claims made against the Insured and notified to Insurers (via brokers) during the period of insurance arising from treatment provided on or after the policy commencement date (or retroactive date where applicable). This policy does not provide cover in relation to:

- Events that occurred prior to the commencement date of the policy (or retroactive date if applicable);
- Claims made after the expiry of the period of cover even though the event giving rise to the claim may have occurred during the period of cover;
- Claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy;
- Claims made, threatened or intimated against you prior to the commencement of the period of cover;
- Facts or circumstances of which you first became aware prior to the period of cover, and which you knew or ought reasonably to have known had the potential to give rise to a claim under this policy;
- Claims arising out of circumstances noted on the Proposal Form for the current period of cover or on any previous Proposal Form.

However, where you give notice in writing to Insurers (via brokers) of any facts that might give rise to a claim against you as soon as reasonably practicable after you become aware of those facts but before the expiry of the period of cover, the policy will, subject to the policy terms and conditions, cover you notwithstanding that a claim is only made after the expiry of the period of cover.

This Proposal Form can be completed electronically or by hand and must be signed and dated by an authorised representative of the Insured. All hand written notes must be clearly legible and all questions should be answered fully, stating “NIL” or “NONE” as applicable. Incomplete answers may delay quotation.

Please attach all supporting documents and include as much detail as possible, using the additional sheets as required. It is the duty of the proposer to disclose all material facts to underwriters. For the purposes of the proposal and for all purposes relating to any policy issued pursuant to this proposal, a “material fact” shall be deemed to be one that would be likely to influence the insurers’ judgment and acceptance of your proposal.

You should familiarise yourself with our standard form of policy for this type of cover before submitting this proposal.

If you are unsure of the material relevance of a fact or item of information, it is best to be cautious by disclosing anything which might conceivably influence the insurer's consideration of your proposal.

Section 1 – General Information

1.1 Name of Organisation:

a) Trading Name *(if different):*

b) How long has the establishment been trading under the above name?

1.2 Principal Trading Address:

Postcode:

Country:

Registered Address *(if different)*:

Postcode:

Country:

*For additional locations please use the Supplementary Information section (**Section 10**), which can be found at the end of this Proposal Form.*

1.3 a) Date of Establishment (DD/MM/YYYY):

b) Contact Telephone Number:

c) Website:

d) Contact Email:

Section 2 – Business Information

2.1 Please confirm, in respect of your past, present and future practice:

a) Gross Fee Income/Turnover/Gross Receipts (excluding sale of goods) for the past financial year:

b) Gross Fee Income/Turnover/Gross Receipts (excluding sale of goods) for the current financial year:

c) Approximate number of patients/clients during the past financial year:

d) Approximate number of patients/clients during the current financial year:

2.2 Please give a full description of your business activities for which cover is required:

2.3 Please note if you are involved in any of the following and where indicated with an asterisk (*), complete the relevant Addendum seen at the end of this Proposal Form.

Unit	Involvement (Please Tick)	% of Total Income
Assisted Conception Unit*		
Autologous Bloodbank		
Clinical Research Establishment*		
Health and Fitness Centre/Gym*		
Industrial/Occupational Health and Safety*		
Health Screening Centre/Mobile Unit*		
Inoculation/Travel Centre		
Medical Personnel/Employment Agency*		
Medical Teaching Facility		
Nursing Teaching Facility		
Pathology Laboratory*		
Repatriation &/or Ambulance Service*		

2.4 What, if any, substantial changes in your activities or major new developments are likely to occur within the next 12 months? Please provide full information.

Section 3 – Qualifications and Licensing

3.1 Are you licensed and registered in accordance with the applicable regulatory body or law to practise those procedures at your given specified address for which indemnification is required?

Yes ☐ **No** ☐

If no, please provide a full explanation for these circumstances.

3.2 Please identify your memberships or registration with Association or Professional Bodies or Licensing Authorities.

3.3 Has membership of or registration with such bodies ever been suspended, withdrawn, amended, declined or had conditions imposed?

Yes ☐ **No** ☐

If yes, please provide full details below.

3.4 Do you ensure and record that, at all times, all Registered Medical and Dental Practitioners are members of a Medical/Dental Defence organisation, recognised by your National Medical/Dental Association, or are otherwise fully insured for their own Malpractice?

Yes ☐ **No** ☐

*If no, please note that this policy is designed to cover claims made against the insured. If cover is also required for claims made against registered medical dental practitioners for work performed for the insured, please supply a list of all such practitioners for whom coverage is required in the supplementary section (**Section 10**) at the end of this Proposal Form.*

This list should state the name, date or birth, qualifications and practice of each practitioner. Furthermore, please confirm whether or not the practitioners are employed by the insured or are self-employed.

Section 4 – Medical Staff and Procedures

4.1 Are any counselling services made available to the patients?

Yes ☐ **No** ☐

If yes, please indicate in which of the following categories:

	Number of counsellors	Employed	Self-employed	Number of patients
Assisted Conception				
Drug/Alcohol Dependency				
Elective Cosmetic				
Elective T.O.P				
Gender Reassignment				
HIV/HEP/STD				
Sterilisation				

Other (please specify):

4.2 Do all counsellors hold appropriate qualifications?

Yes ☐ **No** ☐

Please provide details of qualifications held:

4.3 Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases (ie. Hepatitis, H.I.V. etc) or any other impediment which may affect the performance of his/her professional duties or place patients/clients at risk?

Yes ☐ **No** ☐

If Yes, what procedures are in place:

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4.4 Please state the total number of persons involved in the following capacities:

	Employed by the Insured	Self-employed
Psychiatrists		
Other non-procedural Physicians		
Cosmetic Surgeons		
Orthopaedic Surgeons		
Other Surgeons		
Anaesthetists		
Obstetricians		
Gynaecologists		
Lab/Path Technicians		
Dentists		
Midwives		
Nurse Anaesthetists		
Nurses – Day		
Nurses - Night		
Pharmacists		
Paramedics		
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries – Day		
Auxiliaries – Night		
Counsellors		
Directors/Partners/Principals		
Clerical/Administration		
Other (please specify)		
Other (please specify)		

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Section 5 – Exposure information

5.1 Please state:

- **A.** Total number of day care beds:
- **B.** Total number of overnight beds:
- **C.** Percentage of patients in the last year who have come from USA/Canada:
- **D.** Percentage of patients in the last year who may be resident in Britain who come from USA/Canada:

5.2 Do you provide facilities for the sterilisation of instruments in accordance with current guidelines?
Yes ☐ **No** ☐

If No, please provide details of what arrangements are in place for this.

If Yes, do you ensure that effective cross-infection control methods are employed?

5.3 Do you have a protocol for needlestick injuries?
Yes ☐ **No** ☐
If No, please give full details.

5.4 Please give full details of what records are kept, where and how they are stored and for how long they are retained:

It is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

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Section 6 – Premises Coverage

If you require Public Liability Insurance, please complete the following section.

6.1 Please give full details about the premises, including number of buildings and their age, and any anticipated material developments:

a) Number of buildings?

b) Please supply brief details of legislation that applies to the testing and servicing of water tanks, air conditioning units etc.:

c) Are lifts, hoists, escalators and similar regularly serviced under contract?
Yes ☐ **No** ☐

6.2 What premises functions/facilities do you sub-contract?

6.3 What procedures are in place to ensure that sub-contractors carry adequate insurance and name your organisation as an additional Insured to their insurances?

6.4 Do the premises comply with current fire precaution/prevention requirements?
Yes ☐ **No** ☐
If No, please provide details.

6.5 Are staff instructed and kept regularly appraised in fire and emergency procedures?
Yes ☐ **No** ☐

6.6 Do the premises have an emergency electrical system?
Yes ☐ **No** ☐

6.7 Do you provide facilities for the safe collection, storage and disposal in accordance with current guidelines/legislation of ‘sharps’ and dressings, surgical waste and so on?
Yes ☐ **No** ☐

6.8 Do you ensure that blood, blood products and all other medical and commercial waste are safely disposed of in accordance with current guidelines and legislation on the subject?
Yes ☐ **No** ☐

Section 7 – Previous Insurance History

7.1 Who are the present Medical Professional and/or Public Liability Underwriters of the Insured?

7.2 Has prior coverage been made on a **claims-made** basis?
Yes ☐ **No** ☐

If Yes, what is the retroactive date (DD/MM/YYYY)?

7.3 What are the present policy limits of insurance?

7.4 What is the amount of self-insured excess for each policy?

7.5 What is the expiry date of the present policies (DD/MM/YYYY)?

7.6 Has any application for this type of insurance cover ever been:
Declined ☐ **Cancelled** ☐ **Required Special Terms** ☐ **None of the Above** ☐

*If any of the above are applicable, please provide detailed explanation(s) and any additional information that may be required in the supplementary section at the end of this Proposal Form (**Section 10**).*

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Section 8 – Incidents, Complaints and Claims

8.1 Do you manage claims in-house?
Yes ☐ **No** ☐
Please attach details.

8.2 Please list all claims made against your organisation and all circumstances that could give rise to a complaint and/or claim during the past ten years.

- If no claims have been made, please state "None" in the first column of the below table.
- Should you require additional space, please use the supplementary section at the end of this Proposal Form (**Section 7**).
- Please provide dated copies of any claim sheets from previous insurer(s) if you hold them.

Claim/Complaint/Incident	**Status (Open/Closed)**	**Incident Date**	**Reserve Amount**	**Total Value**	**Description/Nature of Allegations**

8.3 Have all of the previously declared claims been notified to your previous underwriters?
Yes ☐ **No** ☐

8.4 Have all of the previously declared claims been accepted by your previous underwriters?
Yes ☐ **No** ☐

8.5 Please indicate the limit(s) of indemnity which you require quotations for.

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Section 9 – Declaration

Please use the supplementary section (**Section 10**) to add any further information which may be required to fully answer the previous questions.

I/We the undersigned authorised Insured Person(s), after enquiry declare as follows:

I am/We are authorised to make this Proposal.

I/We have read and understood the notice to the Proposed Insured on the front of this Proposal Form.

I/We declare that the statements and particulars contained in the Proposal and the accompanying documents (if any) that I/we have provided, are true and complete and that I/we have not mis-stated or suppressed any material facts.

I/We undertake to inform Insurers (via brokers) of any material alteration to these facts occurring before completion of the contract of insurance. However, the duty to disclose material facts continues after the completion of the Proposal Form and throughout any period of insurance (and any extension thereto), upon which this Proposal Form was used as the basis of the contract of insurance.

Signing this Proposal Form does not bind either the proposer or Insurers to complete this

Signature of authorised Individual/Partner/Principal/Director:

Signature:	**Date:**

Print Name:	
Position:	
Phone:	
Email:	

Section 10 – Supplementary Information

Please use this space to record the answers to any questions for which you require additional space, noting the appropriate question number.