MS Amlin

# Medical Malpractice

## Fertility Clinics Proposal Form

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# 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.

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# Medical Records

*Please note it is a requirement of this policy that all records must be retained for a minimum period of 10 years, and in the case of minors, 10 years from majority. In the case of a patient with a mental incapacity, records must be retained indefinitely. All records must be retained in accordance with data protection law.*

## Section 1 – General Information

**1.1** Name of Insured:

**a)** Trading Name (if different):

**1.2**

| Address of Insured |
| --- |
| ___________________________<br>___________________________<br>___________________________<br>Postcode:<br>Country: |

*For additional locations please complete **Section 7**.*

**1.3 a)** Date of Birth (DD/MM/YYYY): / /

**b)** Contact Telephone Number:

**c)** Contact Email:

**1.4** Please provide your HFEA Licence number:

**1.5** If you operate as a satellite clinic, please provide the name and license number together with the name and HFEA License number with whom you are affiliated:

**1.6** Please list the associations, professional bodies and regulatory organisations with whom you hold a licence/membership

**1.7** Has your membership or registration with any of the above bodies ever been refused, suspended, withdrawn or had conditions issued/imposed?

**Yes** ☐ **No** ☐ *If you have answered "Yes", please provide details below:*

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## Section 2 – Financial Information

**2.1** Please provide the following information for the past, current and future financial years:

| | Past Financial Year | Current Financial Year | Next Year (Estimate) |
|---|---|---|---|
| Gross Revenue | | | |
| Operating Profit/Loss | | | |
| Net Cash | | | |

**2.2** Have you ever been declared bankrupt?

**Yes** ☐ **No** ☐ *If you have answered "Yes", please provide details below:*

## Section 3 – Professional Services

**3.1** Please provide the number of IVF cycles you performed in the last 12 months and an estimate number for the next 12 month period:

| Past Financial Year | Current Financial Year | Next Year (Estimated) |
|---|---|---|
| | | |

**3.2** Is all donor semen screened, cryopreserved and quarantined in line with current HFEA code of practice?

**Yes** ☐ **No** ☐

**3.3** Are any clinical trials undertaken?

**Yes** ☐ **No** ☐ *If you have answered "Yes", please provide details below:*

**3.4** Do you provide management services to other institutions or vice versa?

**Yes** ☐ **No** ☐ *If you have answered "Yes", please provide details below:*

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## Section 4 – Medical Staff & Procedures

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

- ☐ Artificial Insemination by Donor
- ☐ Artificial Insemination by Husband (AIH)
- ☐ Assisted Hatching
- ☐ Counselling Services
- ☐ Egg Collection/Harvesting
- ☐ Egg Donation
- ☐ Embryo Transfer
- ☐ Frozen Embryo Transfer (FET)
- ☐ Gamete Intra-Fallopian Transfer (GIFT)
- ☐ Genetic Screening
- ☐ Intracytoplasmic Sperm Injection (ICSI)
- ☐ Intrauterine Insemination (IUI)
- ☐ In Vitro Fertilisation (IVF)
- ☐ In Vitro Maturation (IVM)
- ☐ Pronuclear Stage Embryo Transfer (PROST)
- ☐ Storage of Embryos
- ☐ Storage of Gametes
- ☐ Storage of Semen for Oncology Patients
- ☐ Surgical Sperm Retrieval (SSR)
- ☐ Tubal Embryo Transfer (TET)
- ☐ Other *(Pease Specify Below)*

## Section 5 – Medical Staff and Procedures - continued

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

| Occupation | Employed by the Insured | Self Employed |
|---|---|---|
| Medical Practitioners | | |
| Nurses | | |
| Embryologists | | |
| Anaesthetics | | |
| Radiographers | | |
| Sonographers | | |
| Counsellors | | |
| Healthcare Assistants | | |
| Laboratory Technicians | | |
| Clerical / Administration | | |
| Other *(Please Specify Below)* | | |
| Other *(Please Specify Below)* | | |

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**5.2** A condition precedent to the MS Amlin policy states that all employed Medical Practitioners are to hold their own Medical Malpractice insurance policy at all times. If you require a quotation where this requirement is waived please provide full details below:

| Practitioners Name | Practitioners Profession & Qualifications | Practitioners Claim History | Practitioners Current Insurance Provisions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Section 6 – Insurance History & Current Requirements

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

| Claim/Complaint/ Incident | Open/Closed (Please Circle) | Incident Date | Reserve (£/€) | Total (£/€) | Description/Nature of Allegations |
|---|---|---|---|---|---|
| | Open/Closed | / / | | | |
| | Open/Closed | / / | | | |
| | Open/Closed | / / | | | |

**6.2** Please provide details of your current insurance arrangements:

Name of insured: Renewal Date:

Limit of Indemnity: Retroactive Date:

Excess Renewal:

**Policy Basis:** Claims Made **Yes** ☐ **No** ☐ Losses Occurrence **Yes** ☐ **No** ☐

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**6.3** Insurance Requirements:

| Please select one box in each of the columns below | | | |
|---|---|---|---|
| **Limit of Indemnity Option** | | **Excess Option** | |
| £1,000,000 | ☐ | £15,000 each and every claim | ☐ |
| £2,000,000 | ☐ | £25,000 each and every claim | ☐ |
| £5,000,000 | ☐ | £50,000 each and every claim | ☐ |
| £10,000,000 | ☐ | | |

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## Section 7 – Declaration

*Please use the supplementary section (**Section 8**) 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 insurance.

Signature of authorised Individual/Partner/Principal/Director:

| **Signature:** | | **Date (DD/MM/YYYY):** |
|---|---|---|
| | | / / |
| **Print Name:** | | |
| **Position:** | | |
| **Phone:** | | |
| **Email:** | | |

## Section 8 – Supplementary Information

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

A Member of MS&AD INSURANCE GROUP