Medical Malpractice

International Non-Hospital Medical/Surgical 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):

1.2 Principal Trading Address: Registered Address (if different):

Postcode: Postcode:

Country: Country:

*For additional locations please complete **Section 10**.*

1.3 **a)** Date Established:

b) Contact Telephone Number:

c) Website:

d) Contact Email:

1.4 Type of Organisation:

1.5 Tax Status: **For Profit** ☐ **Not For Profit** ☐ **Government Entity** ☐ **Public** ☐

1.6 Do you provide management services to other institutions or vice versa?
Yes ☐ *– give details below* **No** ☐

1.7 Please list the associations, professional bodies and regulatory organisations with whom you hold a license/membership:

1.8 Have you ever had a dispute with any regulatory body regarding an Inspection Report?
Yes ☐ *– give details below* **No** ☐

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	New Year (Estimate)
Gross Revenue			
Operating Profit/Loss			
Net Cash			

Section 3 – Professional Services

3.1 Please provide full description of the professional healthcare services for which cover is sought:

3.2 Please give examples of where you perceive your main exposures to be and possible areas where a claim or loss may arise:

(Please ensure you attach any supporting literature, including marketing and press releases, which are relevant to the business. This coverage will only apply to professional services as described here and in any additional pages so please be thorough in the description of your business).

Section 4 – Exposure Information

Please complete the following tables as comprehensively as possible with the most up to date information available.
If possible complete the information applicable to the policy period for which cover is sought.

4.1 Do you have inpatient facilities?

Yes ☐ – if Yes *please complete table below* **No** ☐

a) Please complete the following with the total number of each type of **inpatient bed** and the approximate percentage occupancy during each year.

Bed Count	Past Year	Occupancy %	Current Year	Occupancy %	Next Year	Occupancy %
Adult						
Child						
Elderly						
Other (please specify)						
Other (please specify)						

b) Please complete the following table, specifying each type of treatment visit undertaken by your organisation:

Type	Past Year (estimated number)	Current Year (estimated number)	Next Year (estimated number)

*If you are able to provide more comprehensive exposure details, please detail these in **Section 10**.*

4.2 Are there any anticipated any material changes to your activities in the forthcoming 12 months?

Yes ☐ – if Yes, please *give details below* **No** ☐

Section 5 – Medical & Non–Medical Staff

5.1 Please complete details of your medical & non-medical staff, clearly identifying those for which coverage under this insurance is sought.

	Employed		Non-Employed			Employed		Non-Employed	
Coverage Required?	Yes	No	Yes	No	Coverage Required?	Yes	No	Yes	No
Anaesthetics					Complementary				
Cosmetic Surgeons					Dentists				
General Practitioners					Lab Technicians				
General Surgeons					Midwives				
Gynaecologists					Nurse Anaesthetists				
Obstetricians					Nurse Practitioners				
Ophthalmology					Paramedics				
Orthopaedic Surgeons					Pharmacists				
Psychiatrists					Registered Nurses				
Radiologists					Other (please specify below)				
Trainee Doctors					Other (please specify below)				

5.2 Have the numbers of medical staff providing treatment, care or professional advice changed significantly over the past 5 years? **Yes** ☐ **No** ☐
*If Yes, please provide details by completing **Section 10**.*

5.3 Do you require that all professionally qualified medical staff providing treatment, care or professional advice?

a) Are registered with or licensed by the relevant government regulatory body or licensing and registration body? **Yes** ☐ **No** ☐

b) Are adequately trained and competent for their role? **Yes** ☐ **No** ☐

c) Are adequately supervised under the appropriate management? **Yes** ☐ **No** ☐

d) Are re-credentialed on at least an annual basis, or in line with any professional/statutory requirement, where required? **Yes** ☐ **No** ☐
If No, how often are staff providing treatment, care or professional advice re-credentialed?

5.4 Do you require that all **non-employed** staff providing treatment, care or professional advice?

a) Carry their own medical professional liability insurance or maintain indemnity via a Medical Defence Organisation?
Yes ☐ **No** ☐ *- If Yes, please specify the limits required*

b) Provide evidence of this coverage annually?
Yes ☐ **No** ☐

Section 6 – Risk Management & Quality Assurance

6.1 Do you maintain a staff member responsible for risk management?
Yes ☐ **No** ☐

6.2 Do you have a documented risk management programme?
Yes ☐ **No** ☐ *- If Yes, please attach details*

6.3 Do you provide facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that cross infection control methods are employed?
Yes ☐ **No** ☐
If you do not have an in-house sterilisation facility, please state below what arrangements you have in place.

6.4 Do you comply with the current guidelines for the safe collection & disposal of any clinical/medical waste products?
Yes ☐ **No** ☐

6.5 Are your Medical Records
Written ☐ **Electronic** ☐

6.6 How long are medical records retained from the date of treatment?
Please note it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in any case of minors, 10 years from majority. In the case of a patient with a mental incapacity, records are retained indefinitely.

6.7 Is informed consent obtained from each patient and documented in the medical record?
Yes ☐ **No** ☐ - *If No, how often is informed consent obtained?*

6.8 Do you have a formal programme for clinical quality assurance?
Yes ☐ **No** ☐ *- If Yes, please attach details*
Please comment below how clinical quality is maintained in line with best practice within your industry and how this is benchmarked against your peers:

Section 7 – Incidents, Complaints & Claims

7.1 Do you have a written procedure for the reporting of incidents and adverse events?
Yes ☐ **No** ☐

7.2 Do you have a complaints manager and a written procedure for the handling of patient complaints?
Yes ☐ **No** ☐

7.3 Do you currently manage claims in house?
Yes ☐ **No** ☐

7.4 During the last 10 years has any claim been made, defended or settled, or has any malpractice or negligence been alleged against you?
Yes ☐ **No** ☐

7.5 Are there any circumstances which may result in a claim against you or any prior corporate practice, predecessors in business or any present or former Partner, Principal or Director or Professional Practitioner?
Yes ☐ **No** ☐

7.6 Has any Partner, Principal or Director or member of staff ever been subject to Disciplinary Proceedings for professional misconduct?
Yes ☐ **No** ☐

If you have answered "Yes" to any of the above, please confirm that you have notified such matters to your current insurers. If No, please explain why not below, detailing the outcome & details of those matters.

7.7 If you have answered "Yes" to any of the above, please provide full details below complete information on all claims and circumstances, including full financial details. Please also provide dated copies of the claims sheets from any previous insurers.
*For additional space and for definitions of the above terminology please complete **Section 10**.*

Claim Status	Claimant/Claim No.	Incident Date	Date of Complaint	Incurred Indemnity	Incurred Expenses	Description

7.8 Please provide details of any third party administrator, loss adjustor or legal firm who you currently use in the handling of your claims.

Section 8 – Medical Professional Liability Coverage Requirements

8.1 Please advise the first day that cover is required (DD/MM/YYYY):

8.2 Please provide full details of your medical professional liability cover for the past 5 years:

Year	Insurer	Period of Cover	Limit of Indemnity	Excess	Premium
Current Year					

8.3 Has prior cover been on a **claims made** basis? **Yes** ☐ **No** ☐

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

8.4 Please provide details of coverage requested:

a) Limit of Indemnity:
b) Excess:

8.5 Has any proposal for similar insurance been made on behalf of the proposer's business, any predecessor of the business, or any Partner, Principal or Director ever been declined or has such insurance ever been cancelled, had renewal refused or had any special terms imposed (other than general market increases)?
Yes ☐ – *If Yes, please provide details below* **No** ☐

8.6 Please provide details of the territories / legal jurisdiction(s) in which coverage is required:

8.7 Please describe any statutory, legal or administrative provision which might serve to limit or otherwise affect the institution's liability or loss exposure (e.g. statutory caps on damages, tort reform etc.):

8.8 Please outline any further information that you believe may affect Underwriters' consideration of the risk:

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 insurance.

Signature of authorised Individual/Partner/Principal/Director:

Signature:	**Date:**
	DD/MM/YYYY

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.