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# Medical Malpractice

## Non Hospital Medical/Surgical Providers

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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 Organisation:

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

**1.2** Principal Trading Address:
Postcode:
Country:

Registered Address (if different):
Postcode:
Country:

*For additional locations please use the Supplementary Information section (**Section 9**), which can be found at the end of this Proposal Form.*

**1.3 a)** Date of Establishment:

**b)** Contact Telephone Number:

**c)** Website:

**d)** Contact Email:

**1.4** What type of organisation are you?

**1.5** Please confirm the current tax status of your organisation:
**For Profit** ☐ **Not for Profit** ☐ **Public** ☐ **Government Entity** ☐

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

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

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

## Section 2 – Business Information

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

**a)** Gross revenue in the past financial year:

**b)** Gross revenue in the current financial year:

**c)** Estimated gross revenue in the future financial year:

**d)** Operating profit/loss in the past financial year:

**e)** Operating profit/loss in the current financial year:

**f)** Estimated operating profit/loss in the future financial year:

**g)** Net Cash in the past financial year:

**h)** Net Cash in the current financial year:

**i)** Estimated Net Cash in the future financial year:

## Section 3 – Professional Services

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

## Section 4 – Exposure Information

**4.1** Do you have any inpatient facilities?
**Yes** ☐ **No** ☐
*If yes, please show the number of occupied beds for each section for the previous, current and estimated year.*

| **Beds** | **Previous Year** | **Current Year** | **Next Year (Estimate)** |
|---|---|---|---|
| Adult | | | |
| Child | | | |
| Elderly | | | |
| Mental Health | | | |
| Mental Health (sectioned) | | | |
| Other (please specify) | | | |
| Other (please specify) | | | |

*For additional types of bed, please provide further details in the supplementary information section (**Section 9**), at the end of this Proposal Form.*

**4.2** Please provide details of patient numbers:

| **Patient Encounters** | **Previous Year** | **Current Year** | **Next Year (Estimate)** |
|---|---|---|---|
| | | | |
| Outpatient Visits | | | |

Do you anticipate any material changes to your activities in the forthcoming 12 months?
**Yes** ☐ *- give details below* **No** ☐

## Section 5 – Medical Staff and Procedures

**5.1** Please provide the numbers of your medical staff for the forthcoming period of insurance:

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

**5.2** Do you require that all non-employed medical staff:

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

**b)** Provide evidence of this coverage on an annual basis, as part of your practitioner credentialing process?
**Yes** ☐ **No** ☐

**5.3** 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 what arrangements you have in place below.*

**5.4** Do you comply with the current guidelines for the safe collection and disposal of any clinical/medical waste products?

**Yes** ☐ **No** ☐

**5.5** Are your medical records:

**Written** ☐ **Electronic** ☐

**5.6** 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 the case of minors, 10 years from majority. In the case of a patient with a mental incapacity, records will be retained indefinitely.*

## Section 6 – Incidents, Complaints and Claims

**6.1** Do you manage claims in-house?
**Yes** ☐ *- please attach details* **No** ☐

**6.2** 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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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## Section 7 – Insurance History/Current Requirements

**7.1** Please provide full details of your previous and current medical professional liability cover:

| Year | Insurer | Type of cover | Period of Cover | Limit of Indemnity | Excess | Premium | Claims Made Basis of Cover? |
|---|---|---|---|---|---|---|---|
| | | | | | | | Yes / No |
| | | | | | | | Yes / No |
| | | | | | | | Yes / No |

**7.2** 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 and additional information in the Supplementary Section (**Section 9**), which can be found at the end of this Proposal Form.*

**7.3** Please confirm if you require cover for past work (retroactive cover).
**Yes** ☐ **No** ☐
*If yes, please confirm the date from which you have held **continuous** cover on a **claims made** basis.*

Date of Cover:

**7.4** Please provide details of the Limit of Indemnity and Excess you require:

**Limit of Indemnity:**
**Excess:**

**7.5** Has any proposal for similar insurance ever been made on behalf of the proposer's business, any predecessor of the business, or any Partner, Principal, 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** ☐ **No** ☐
*If yes, please provide details below:*

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

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## Section 8 – Declaration

*Please use the supplementary section (**Section 9**) 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:** | |

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## Section 9 – Supplementary Information

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

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