Medical Malpractice

Registered Medical & Supplementary Practitioners 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.

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):*

Address of Insured	Trading Address
_____ _____ _____ Postcode: Country:	_____ _____ _____ Postcode: Country:

*For additional locations please complete **Section 6**.*

1.2 a) Date of Birth:

b) Contact Telephone Number:

c) Contact Email:

1.3 Please list the Licensing/Registration Body with which you hold a valid licence/membership:

1.4 Please also provide:

a) Your registration number:

b) Your registration date (DD/MM/YYYY):

c) Your registration type:

d) The date of your first registration (DD/MM/YYYY):

1.5 Please list the associations and any other relevant regulatory bodies or organisations with which you hold a licence or membership:

1.6 Has membership of or registration with any licensing body ever been:

Refused ☐ **Suspended** ☐ **Withdrawn** ☐ **Had Conditions Imposed** ☐

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 6**).*

1.7 Please confirm for which discipline(s) of medicine you require cover:

Audiologist	☐	Cardiologist	☐	Dentists*	☐	Dermatologist	☐	Dietician	☐
Endocrinologist	☐	First Aider	☐	General Practitioner	☐	Gynaecologist	☐	Haematologist	☐
Immunologist	☐	Medical Lab Technician	☐	Microbiologist	☐	Neurologist	☐	Nuclear Medicine	☐
Nurse	☐	Nutritionist	☐	Occupational Therapist	☐	Oncologist	☐	Ophthalmologist	☐
Optometrist/ Optician	☐	Orthodontist*	☐	Orthopaedics*	☐	Paediatrician	☐	Paramedic	☐
Pathologist	☐	Perfusionist	☐	Pharmacist	☐	Physiologist	☐	Physiotherapist	☐
Physicians	☐	Prosthetist/ Orthotist	☐	Psychiatrist	☐	Radiographer	☐	Radiologist	☐
Sonographer	☐	Speech Therapist	☐	Surgeon*	☐	Urologist	☐	Venereologist	☐

Other* (please specify)

*For all items marked with an asterisk (*), please provide further details in the supplementary information section (**Section 6**) and complete the required addendums found at the end of this Proposal Form.*

Section 2 – Business Information

2.1 Please confirm, in respect of the number of patients you have treated in the discipline(s) you require cover:

a) Number of patients in the previous policy year:

b) Number of patients in the current policy year:

c) Number of patients expected next policy year:

2.2 Please provide details of your income based on the activity(s) you require cover for. Estimate values if this is a new business.

a) Total gross income in the previous policy year:

b) Total gross income in the current policy year:

c) Total gross income expected in the next policy year:

Section 3 – Past Insurance History

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

Year	Insurer/MDO	Period of Cover	Limit of Indemnity	Excess	Premium	Claims Made Basis of Cover?

3.2 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(s) and any additional information that may be required in the supplementary section at the end of this Proposal Form (**Section 6**).*

3.3 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 (DD/MM/YYYY):

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

Limit of Indemnity:
Excess:

Section 4 – Claims History

4.1 Please list all claims made against the proposer 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 6**).

Claim / Complaint / Incident	Status	Date the claim was made	Date the claim was notified	Reserve amount	Total value claimed and total value paid (if paid)	Description / Nature of allegations	Deductible

Section 5 – Declaration

*Please use the supplementary section (**Section 6**) 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 6 – Supplementary Information

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

Addendum – Dentists and Surgeons

Dentist Addendum

Area	Percentage Split	Area	Percentage Split
Aesthetics and Cosmetic Dentistry		Orthodontics	
Anaesthesia/Sedation		Surgical Periodontal Treatment	
General Dentistry		Other (please specify)	
Implantology		Other (please specify)	
Oral Surgery		Other (please specify)	

Surgeon Addendum

Surgery	Percentage Split	Surgery	Percentage Split
Bariatric		Spinal Surgery	
Cardiac		Surgery (Minor)	
Elective Cosmetic		Surgery (Intermediate)	
Elective TOP		Surgery (Major)	
Gender Reassignment		Other (please specify)	
Orthopaedic		Other (please specify)	