MEDI|GUARD

ENTITY/CORP MEDICAL MALPRACTICE

Proposal Form

IMPORTANCE NOTICE TO THE PROPOSER:

It is important that you provide us with all the information that Insurers require to be able to provide a quotation. Any 'material fact' any information which may alter the judgement of an insurer in assessing the risk must be disclosed to the Insurers. Any 'material change or information' must be disclosed to the Insurers. A 'material change' is any information which may alter the judgement of an Insurer that has not previously been disclosed as a material fact.

HOW TO COMPLETE THIS FORM:

This proposal form must be completed in black ink by the proposed individual. If you require extra space to answer the questions or provide any other material information, please use the additional information section at the back of the form.

SECTION A – GENERAL INFORMATION

1.1 INSURED NAME: CONTACT NAME:

ADDRESS:

POSTCODE:

TELEPHONE NO: WEBSITE:

EMAIL ADDRESS:

1.2

PLEASE STATE:

The date the business was established: D M YEAR

The date the business started trading: D M YEAR

1.3

Please provide details of all trading addresses, including any overseas trading addresses, below:

Address 1		Country
Address 2		Country
Address 3		Country
Address 4		Country

1.4

Please state whether you have ever been refused membership of any association, professional body or Self-regulating organisation or have had any licence suspended, revoked or had special conditions imposed: Yes ☐ No ☐

If yes, please provide full details:

SECTION A: GENERAL INFORMATION

1.5 Please state who is responsible for the Clinical Risk Management in your business

Name: | Position:

Date joined: D M YEAR | Qualification:

1.6 Is any work sub-contracted? Yes ☐ No ☐

1.7 (a) *If yes, please provide full details:*

1.8 (b) Do you require all sub-contractors to maintain their own insurance? Yes ☐ No ☐

1.9 (c) Is there any additional information that should be made known to Underwriters so that they may form a proper estimate of the risk? Yes ☐ No ☐

If yes, please provide full details:

SECTION B: MEDICAL SERVICES INFORMATION.

2.1 Please give details of your gross income / fees:

(a) For the current financial year £

(b) For the next financial year £

(c) Approximately split by:

Private % | Govt / Public % | Charitable %

(d) Approximately split by:

UK (Excl IOM & / or Channel Islands) % | Europe %

USA / Canada % | ROW %

(e) Largest fee for one client £

(f) Average fee for one client £

SECTION B: MEDICAL SERVICES INFORMATION.

2.2 Please list your three largest projects undertaken in the last 5 years (including name of clients and fees earned)

1

2

3

2.3 Please enclose copy of standard contract.

2.4 Please provide a full occupational breakdown of the number of staff in categories stated below:

Type Clinical	Employed	Self employed
Anaesthetists:		
Audiologists:		
Beauty therapists:		
Care staff:		
Chiropodists/podiatrists:		
Chiropractors/Osteopaths:		
Clinical scientists/specialists:		
Complementary therapists:		
Dentists:		
Dental care practitioners:		
Dieticians/nutritionists:		
General Practitioners:		
General surgeons:		
Gynaecologists:		
Laboratory technicians:		
Midwives:		
Nurse anaesthetists:		
Nurse practitioners:		
Nurses – general:		
Obstetricians:		
Occupational therapists:		
Ophthalmologists:		

SECTION B: MEDICAL SERVICES INFORMATION.

2.5 Do you require the following staff to maintain their own cover, through their professional body or equivalent?

	Yes	No
(a) Dentists		
(b) Doctors / Physicians		
(c) Midwives		
(d) Nurses		
(e) Occupational nurses		
(f) Occupational Physicians		
(g) Paramedics / ECPs		
(h) Pharmacists		
(i) Psychiatrists		
(j) Psychologists		
(k) Surgeons		
(l) Therapists / Other Professional (including Counsellors and Complementary Practitioners)		

If No, then please provide full details:

(Please note that additional information may be required if specific cover for any of the medical professions listed above is to be included within your own policy)

2.6 Do you ensure that all references, qualifications and right to work status are taken up and that all appropriate police checks are carried out on all staff? Yes ☐ No ☐

If No, then please provide full details:

SECTION B: MEDICAL SERVICES INFORMATION.

		Yes	No
2.7	Do you provide any training / teaching facilities?	☐	☐
2.8	Do you provide any facilities for the sterilisation of instruments?	☐	☐
2.9	Are any counselling services provided?	☐	☐
2.10	Are you duly licenced in accordance with Care Standards Act 2000 and are you registered with the Care Quality Commission (CQC) or equivalent body?	☐	☐

2.11 Has your registration with the CQC (or equivalent body) ever been:

	Yes	No
(a) Approved with conditions	☐	☐
(b) Cancelled	☐	☐
(c) Varied	☐	☐
(d) Other	☐	☐

2.12 Have you ever been in dispute with the CQC (or equivalent) regarding an assessment / Inspection report? Yes ☐ No ☐

If yes, please provide details:

2.13 Have you ever been investigated by the CQC (or equivalent), or do you have an investigation pending? Yes ☐ No ☐

If yes, please provide details:

2.14 Have you met all recommendations and requirements from your last CQC (or equivalent) Inspection report? Yes ☐ No ☐

If no – please provide details

SECTION B: MEDICAL SERVICES INFORMATION.

2.15 Please provide the split of activities between:

(a) Residential Care ____ %

(b) Care in the community ____ %

(c) Respite Care ____ %

(d) Occupational Health ____ %

(e) Outreach Work ____ %

2.16 Please provide approximate split between Private and NHS patients.

Private ____ %

NHS ____ %

2.17 Please advise how patients are referred?

2.18 Do you undertake any work for the NHS, where liability is covered by the CNST? Yes ☐ No ☐

If yes, please enclose full details

2.19 Please provide percentage split or number of patients in the following categories:

(a) A&E ____ %

(b) Antenatal ____ %

(c) Assisted Conception ____ %

(d) Clinical Trials ____ %

(e) Cosmetic ____ %

(f) Dental ____ %

(g) Diet / Nutrition ____ %

(e) Disability ____ %

(f) Drug / Alcohol ____ %

(g) Gender Reassignment ____ %

(h) Respite ____ %

(i) STI ____ %

(j) HIV / HEP (including Councelling) ____ %

(k) Intermediate Surgery ____ %

(l) Laser Eye Surgery ____ %

(m) Major Surgery ____ %

(n) Maternity / Obstetrics ____ %

(o) Minor Surgery ____ %

(p) Paediatric ____ %

(q) Plastic / Reconstructive ____ %

(r) Psychiatric ____ %

(s) Residential / Nursing Care ____ %

(t) Terminally ill ____ %

(u) Other (please specify)_ ____ %

SECTION C: INSURANCE.

3.1 Please provide the following:

(a) Current Insurer

(b) Current Limit

(c) Current Deductible

(d) Current Premium

(e) Current Expiry Date D M YEAR

Yes ☐ No ☐

3.2 Have any Lloyd's or any other Insurers ever cancelled, declined, refused to renew or only accepted on special terms, your Malpractice or Public Liability Insurances?

Yes ☐ No ☐

3.3 Have any claims for Malpractice or Negligence ever been made against you or are you aware of any circumstances which might result in such a claim being made against yourselves?

Yes ☐ No ☐

If yes, please enclose full details & use additional sheet if required.

3.4 Please indicate which limited / limits you require quotations for: Please tick as appropriate

£1,000,000 ☐

£2,000,000 ☐

£5,000,000 ☐

£10,000,000 ☐

Other amount (please specify) £

Do you have any other Malpractice or Public Liability Insurance? Yes ☐ No ☐

If yes, please provide details

ADDITIONAL INFORMATION SHEET:

Please use this sheet in reference to any additional information required: Ref Question

SECTION D : DECLARATION

I / We declare that the statements and particulars contained in the proposal form are true and that I have not mis-stated or suppressed any material facts.

I agree that this proposal form together with any other information supplied by me/us shall form the basis of any contract of insurance effected thereon.

I undertake to inform Insurers of any material alterations to these facts occurring before completion of the contract of insurance. However, the duty to disclose material facts continues after completion of the proposal form and throughout any period of insurance (any extension thereto), upon which this proposal form was used as the basis of the contract of insurance.

Signature ……

Print name ……

Date……

This proposal form, duly completed, together with any supplementary information, must be signed in ink. Signature of the form does not bind the Proposer or the Underwriters to complete this insurance.

Data Protection Act – All personal information supplied by you will be treated in confidence by GS London Markets Ltd and will not be disclosed to any third parties except in the process of providing insurance terms, unless your consent has be received or where permitted by law. In order to provide you with products and services this information will be held in the data systems GS London Markets Ltd or our agents or subcontractor.