W.R. Berkley Insurance (Europe), Limited

GENERAL MEDICAL MALPRACTICE INSURANCE

PROPOSAL FORM

IMPORTANT NOTICE TO THE PROPOSER TO COMPLETION OF THIS PROPOSAL FORM

1. Disclosure

Any "material fact" must be disclosed to Insurers.
A "material fact" is any information which may alter the judgement of an Insurer in assessing the risk.
Any "material change" must be disclosed to 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.

Failure to provide all "material facts" and/or notify all "material changes" may cause the contract of insurance to be void and may result in Insurers repudiating liability entirely.

2. Presentation

This Proposal Form must be completed in ink by an authorised individual, a partner, principal or director of the proposer.
All questions must be answered.
If there is insufficient space to provide answers additional information should be provided on the proposers letter headed paper.
Where available brochures, standard contract conditions, conditions, agreements and letters of appointment should be provided.

Failure to present Insurers with information in an appropriate manner may adversely influence the ability of Insurers to offer terms.

3. Guidance

If in doubt as to the meaning of any question contained within this proposal form or the issues raised in 1) Disclosure and/or 2) Presentation advice should be sought from an insurance advisor in the first instance.

SECTION A – GENERAL INFORMATION

Please provide the following information:

1. Name of Insured(s) to be covered, including the names of any subsidiary companies to be covered. *(please continue on a separate sheet if necessary)*	Date Established	Length of Time Trading (inc start date)

2. Please provide details of the Insured(s) Registered Office:	
Website Address:	Tel No:

3.Please provide details of all Trading Address(es) and any overseas addresses below (please use a separate sheet or the space provided in SECTION E if needed)

4.Have you ever carried out medical activities in any other name, been part of an amalgamation, merger or de-merger or in any way had any material change to your activities? ? If "Yes" please please provide full details below (or on a separate sheet)	Yes ☐ No ☐
5. Is there any corporate or private American or Canadian entity or Individual that has or has had an interest, ownership or control of you or your company? If "Yes" please provide full details below.	Yes ☐ No ☐
6. Are you a member of or registered with any associations, professional bodies or self-regulatory organisations. If "Yes" please provide details below.	Yes ☐ No ☐
7. Are you in possession of relevant licences and/or registrations(s) from the applicable regulatory body or as required by law? If "No" please provide full details below.	Yes ☐ No ☐
8. Has any membership or registration with any such bodies (as detailed in 6 and 7 above) ever been refused on application, suspended, withdrawn or had conditions imposed? If "Yes" please provide full details.	Yes ☐ No ☐

9. Who within your organisation is responsible for Clinical Risk Management?	
Name:	Position;
Date Joined:	Qualifications:

SECTION B – MEDICAL SERVICES INFORMATION

Please provide the following information:

10.Please provide details of your gross income / fees / turnover for the last two financial years and an estimated figure for the forthcoming financial year.

	Year Ended __ / __	Year Ended __ / __	Year Ending __ / __
UK			
Ireland			
Europe			
USA/Canada			
Rest of the World			
Total			

11. Please provide a **full description** of your business activities and attach any sales and marketing brochures/literature about your business.

12. Please provide the percentage of your income derived from each of the disciplines below.

Activity	**Percentage**	**Activity**	**Percentage**
Accident and/or Emergency		Hyperbaric Clinic / Services	
Acquired Brain Injury Rehabilitation		Learning Disabilities	
Addiction Treatment Centres		Medical Employment Agency	
Alternative / Complimentary Therapy		Medical Repatriation	
Ambulatory / Paramedic Services		Medical Training Institution	
Antenatal Clinic		Nutrition/Slimming/Dietary	
Beauty Therapy Clinic		Obstetrics & Maternity	
Clinical Trials		Occupational Health	
Cosmetic Surgery - invasive		Opticians / Optometry	
Cosmetic – non invasive		Out of Hours Primary Care Services	
Counselling		Palliative Care	
Dentistry		Pathology / Laboratory Services	
Diagnostic and Scanning Services		Pharmacy	
Dialysis Services		Psychiatric	
Domicilliary Care		Sports Medicine / Injury	
Elderly Care		Surgery - Minor	
Eye Surgery – Laser / Refractive Eye		Surgery – Major	
Eye Surgery – Other		Other	
Fertility Services		(PLEASE PROVIDE DETAILS BELOW):-	
GP / Primary Care Services			
Health and Fitness Centre			
		Total	**100%**

Please provide details of activities if listed under "Other" above.

13. Do you have any inpatient facilities? If “Yes” please provide details below.		Yes ☐ No ☐
Type of Bed	**Average Daily Occupancy - %**	**Number of Beds**
Acute Care Beds		
Acute Psychiatric Beds		
Acquired Brain Injury Rehabilitation Beds		
Addiction / Rehabilitation Treatment Beds		
Bassinets, Cribs and Cots		
Elderly Care Beds		
Hospice / Palliative Care Beds		
ICU / ITC Beds		
Learning Disability Beds		
Nursing Home Beds		
Psychiatric Rehabilitation Beds		
TOTAL		

14. Do you undertake any outpatient/day case procedures at your facilities? If “YES” please advise (i) the number of procedures (ii) the income generated from these procedures	Yes ☐ No ☐ £
15. Do you own or operate any of the following :	
(i) Pathology Laboratories	Yes ☐ No ☐
(ii) Ambulances or patient transport vehicles	Yes ☐ No ☐
(iii) Air Ambulances	Yes ☐ No ☐
(iv) A blood bank that procures, tests and distributes blood or blood products	Yes ☐ No ☐
(v) CAT scanners, MRI equipment or similar	Yes ☐ No ☐
If “Yes”, is there a maintenance agreement in force with a third party?	Yes ☐ No ☐
16. Do you have any Medical or Nursing teaching facilities and/or do you provide training or tuition to anyone other than your own employees? If “Yes” please provide details below.	Yes ☐ No ☐
17. Do you anticipate any material changes to your activities in the forthcoming 12 months? If “Yes” please provide details below.	Yes ☐ No ☐
18. Do you publish advice or offer medical diagnosis over the internet or any other electronic media that is available to patients? If “Yes” please provide full details below.	Yes ☐ No ☐

19. Please advise the number of persons involved in your business in each of the following categories:

Employee Type	Full and Part Time Employees	Self Employed	Bank / Agency Staff
Doctors			
Cosmetic Surgeons			
Orthopaedic Surgeons			
Other Surgeons (Specify below)			
Obstetricians			
Anaesthetists			
Residential Medical Officers (RMO)			
Psychiatrists			
Radiologists			
General Practitioners			
Other (Specify below)			
Other Medical Personnel			
Laboratory Technicians			
Pharmacists			
Clinical Scientists/Specialists			
Registered Nurses			
Registered Midwives			
Nurse Practitioners			
Radiographers			
Attendant carers			
Complementary Professionals			
Paramedics			
Other (Specify below)			
Non Medical Personnel			
Directors / Partners / Principals			
Clerical/Administration			
Other Employees (Specify below)			

20. Do you require that all professionally qualified healthcare staff, listed above in Q19

(i) Carry their own medical Professional Indemnity Insurance or maintain Indemnity via a Medical Defence Organisation? Yes ☐ No ☐

(ii) Provide evidence of this coverage on an annual basis, as part of your practitioner credentialing processes? Yes ☐ No ☐

(iii) Are registered with and a subscribing member of a Medical Institute or other professional body? Yes ☐ No ☐

If "No" please provide details below.

21. Do you undertake the following for all staff:

(i) Gain references and check the validity of any professional qualifications? Yes ☐ No ☐

(ii) Undertake appropriate police checks on all staff, be they full, part time, temporary or contract? Yes ☐ No ☐

(iii) Ensure that all staff are adequately trained and competent for their role? Yes ☐ No ☐

(iv) Ensure that all staff are adequately supervised under the appropriate management? If "No" please provide details below.	Yes ☐ No ☐
22. Do you operate, in part or whole, as an NHS Independent Treatment Centre or undertake any work for the NHS where liability is covered under the CNST Scheme? If "Yes" please provide details including the revenue relating to this work.	Yes ☐ No ☐
23. Do you sub-contact any work? If "Yes" please provide details of the nature of the sub-contracted work including any one off projects?	Yes ☐ No ☐
24. Do you enter into any written agreement, or operate under a standard form of contract or letter of appointment? If "Yes" please provide a copy.	Yes ☐ No ☐
25. Do you require all sub-contractors to maintain their own medical indemnity insurance cover at all times and for this to be evidenced? If "No" please provide details below.	Yes ☐ No ☐
26. 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? If "No" please provide details below.	Yes ☐ No ☐
27. Do you comply with the current guidelines for the safe collection and disposal of any clinical/medical waste products? If "No" please provide details below.	Yes ☐ No ☐
28. Do you have a protocol for Needlestick injuries? If "No" please provide details below.	Yes ☐ No ☐
29. Are you or have you been involved in any form of clinical trials? If "Yes" please provide full details below	Yes ☐ No ☐
30. Do you maintain and will you continue to maintain accurate descriptive records of all Medical Services provided for a period of at least ten (10) years from the date of treatment, and in the case of a minor, for at least ten (10) years after that minor attains majority? If "No" please provide details below.	Yes ☐ No ☐
31. Is there any further information that should be made known to Underwriters so that they may form a proper estimate of the risk? If "Yes" please provide details below (including any part time activities, details of associated companies and/or links).	Yes ☐ No ☐

SECTION C – CLAIMS INFORMATION

Please advise the following:

32. During the last 10 years any claim has been made, defended or settled, or any malpractice or negligence has been alleged against you?	Yes ☐ No ☐
33. 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 ☐
34. Has any Partner, Principal or Director or member of staff has ever been subject to Disciplinary Proceedings for professional misconduct?	Yes ☐ No ☐
35. 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:	Yes ☐ No ☐

36. **If you have answered "Yes" to any of the above, Provide full details below (or on a separate sheet if you run out of space), complete information on all claims and circumstances, including full financial details. Please also provide dated copies of the claims sheets from any previous insurers.**

SECTION D – INDEMNITY

Please advise the following:

37. Please advise the first day that cover is required: / /

38. Please provide full details of all previous Medical Malpractice cover:

INSURER	PERIOD OF COVER	LIMIT OF INDEMNITY	EXCESS

39. What is the amount of indemnity now required?

40. Has prior cover been on a CLAIMS MADE basis? If "Yes", what is the current retroactive date? / /	Yes ☐ No ☐
41. Has there been continuous cover in place since the retroactive date?	Yes ☐ No ☐
42. Has any proposal for similar insurance made on behalf of the proposer's business, any predecessor of the business, or any Partner, Principal, Director even been declined or has such insurance ever been cancelled, had renewal refused or had any special terms imposed (other than general market increases)? If "Yes" please provide full details below.	Yes ☐ No ☐

SECTION E – ADDITIONAL INFORMATION

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

SECTION F – DECLARATION

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

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

I/We undertake to inform Insurers 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 does not bind the proposer to complete this insurance.

Signature of authorised Individual/Partner/Principal/Director: Date:

Please also print name:

***Data Protection Act** – All personal information supplied by you will be treated in confidence by W.R. Berkley Insurance (Europe), Ltd and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of W.R.Berkley Insurance (Europe), Ltd or our agents or subcontractor.*