AUSTRALIA
CANADA
IRELAND
ISRAEL
UNITED KINGDOM
UNITED STATES
REST OF WORLD

MEDICAL MALPRACTICE

APPLICATION FORM

INTRODUCTION

The purpose of this application form is for us to find out more about you. Completion of this application form does not oblige either you or us to enter into a contract of insurance.

Following a reasonable search you must provide us with all information which may be material to the cover we offer in a clear and accessible manner. Information is material if it would influence our decision whether to insure you, what cover we offer you or what premium we charge you. If you are in any doubt whether a fact or circumstance is material you should disclose it.

HOW TO COMPLETE THIS FORM

Whoever fills out the form must be a principal, director or partner of the applicant company. They should make all the necessary enquiries of their fellow senior management, employees and persons responsible for arranging the insurance to enable our questions to be answered.

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. Once you have completed the form please return it directly to your insurance broker.

SECTION 1 : GENERAL INFORMATION

1.1 Please provide the following details:

Insured name:

Contact name:

Address:

Postcode: Telephone:

Email address: Website:

1.2 Please state:

the date business was established: DD / MM / YY

the date the business started trading: DD / MM / YY

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

Address 1:

Address 2:

Address 3:

Address 4:

1.4 Please state whether you have ever carried out any activities under any other name or have been part of a merger or de-merger: ☐ Yes ☐ No

If yes, please provide full details:

1.5 Please state whether there is any overseas corporate entity or private individual that has or has ever had an interest in or ownership or control of the business: ☐ Yes ☐ No

If yes, please provide full details, including the country of registration of the overseas corporate entity or country of residence of the private individual:

1.6 Please state whether you are a member of, or registered with, any associations, professional bodies or self-regulatory organisations: ☐ Yes ☐ No

If yes, please provide full details:

1.7 Please state whether you hold a valid licence, or are registered with an appropriate regulatory body or as otherwise required by law, to practice your business: ☐ Yes ☐ No

If no, please explain why not:

1.8 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:

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

Name:		Position:	
Date joined:		Qualifications:	

SECTION 2 : MEDICAL SERVICES INFORMATION

2.1 Please state the annual turnover in respect of the following years:

	Last complete financial year MM/YY	Current financial year MM/YY	Estimate for next financial year MM/YY
UK			
Ireland			
Rest of Europe			
Rest of the World			
USA/Canada			
Total			

2.2 Please state the legal structure of the business:

Charity/Not-for-profit: ☐ Public: ☐

Private: ☐ Other: ☐

If you have selected 'other', please provide full details:

2.3 Please provide a full description of the business activities and attach any sales/marketing brochures or other literature:

2.4 Please provide a full breakdown of the percentage of gross income generated from the following activities.

The total of all activities should equal 100%:

Accident & emergency:	%	Medical employment agency:	%
Acquired brain injury rehabilitation:	%	Medical repatriation:	%
Addiction treatment centres:	%	Medical training institution:	%
Alternative/complementary medicine:	%	Nursing:	%
Ambulatory/paramedic services:	%	Nutrition/slimming/dietary etc:	%

Beauty therapy services:	%	Occupational health:	%
Blood bank/plasma services:	%	Ophthalmic surgery – laser/refractive eye:	%
Clinical trials:	%	Ophthalmic surgery – other:	%
Cosmetic surgery:	%	Opticians/optometry:	%
Cosmetic/aesthetic (non-surgical):	%	Out-of-hours primary care services:	%
Counselling:	%	Palliative care:	%
Dentistry:	%	Pathology/laboratory services:	%
Diagnostic and scanning services:	%	Pharmacy:	%
Dialysis services:	%	Physiotherapy/rehabilitation services:	%
Domiciliary care:	%	Psychiatric/mental health services:	%
Elderly care:	%	Sexual health services:	%
Fertility services/assisted conception:	%	Sports medicine/injury:	%
GP/primary care services:	%	Surgery – major:	%
Health and fitness services:	%	Surgery – minor:	%
Hyperbaric clinic/services:	%	Telemedicine/remote services:	%
Learning disabilities:	%	Other:	%
Maternity & obstetrics:	%	Total:	100%

If you have selected other, please provide full details:

2.5 Please state the number of patients or clients treated per annum:

2.6 Please state whether you anticipate any material changes to the activities or the business in the next 12 months: ☐ Yes ☐ No

If yes, please provide details:

2.7 Please state whether you provide any inpatient facilities at the premises: ☐ Yes ☐ No

If yes, please state the following information:

Type of bed	Number of beds	Average number of beds occupied daily
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/HDU beds		
Learning disability beds		
Nursing home beds		
Psychiatric rehabilitation beds		
TOTAL		

2.8 Please state whether you provide any outpatient services: ☐ Yes ☐ No

If yes, please state the following:

a) the number of procedures performed per annum:

b) the annual turnover generated from these procedures: £

2.9 Please state whether any of the following are used for the activities of the business:

a) air ambulances: ☐ Yes ☐ No

b) ambulances or patient transport vehicles: ☐ Yes ☐ No

If yes, do you undertake any emergency response "blue light" activities? ☐ Yes ☐ No

c) CAT scanners, MRI equipment or similar: ☐ Yes ☐ No

If yes, do you have a maintenance agreement in place? ☐ Yes ☐ No

2.10 Please state whether you provide or have any interest in any medical or nursing teaching facilities or whether training is provided to individuals not employed by the business: ☐ Yes ☐ No

If yes, please provide full details:

2.11 Please state whether you publish advice or offer medical diagnosis or treatment over the internet or any other electronic medium, for example, phone apps: ☐ Yes ☐ No

If yes, please provide full details:

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

Type :	Full and part-time employees	Self employed	Bank/agency staff
Clinical			
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:			

Type :	Full and part-time employees:	Self employed:	Bank/agency staff:
Ophthalmologists:			
Optometrists			
Orthopaedic surgeons			
Paramedics/first aiders			
Pharmacists			
Physicians			
Physiotherapists			
Plastic/cosmetic surgeons			
Prosthetists/orthotists			
Psychologists			
Psychiatrists			
Radiographers			
Radiologists			
Resident medical officers (RMO)			
Speech and language therapists			
Surgeons – other			
Non-clinical			
Clerical/administrative			
Directors/partners/principals			
Other employees			
Other clinical personnel			
Other non-clinical personnel			

If you have selected other clinical personnel or other non-clinical personnel, please provide full details:

2.13 Please state your Employer Reference No. (ERN):

2.14 Please provide the wageroll split between the following categories:

a) clerical/admin: £

b) qualified healthcare/clinical staff: £

c) other qualified healthcare/clinical staff: (e.g. doctors) £

d) non-qualified staff healthcare/clinical staff: (e.g. HCAs) £

e) manual staff (e.g. drivers, domestic) £

2.15 Please state whether all clinical staff listed in 2.12:

a) hold their own medical professional indemnity insurance or maintain indemnity via by a Medical Defence Organisation: ☐ Yes ☐ No

b) provide evidence of the coverage in force on an annual basis, as part of your practitioner credentialing process: ☐ Yes ☐ No

c) are registered with the appropriate regulatory body(s): ☐ Yes ☐ No

If no to a), b), or c), please explain why not:

2.16 Please state whether the following are undertaken for all full-time, part-time, temporary and contract staff and valid records maintained:

a) references obtained and any professional qualifications validated: ☐ Yes ☐ No

b) appropriate police background checks: ☐ Yes ☐ No

c) the provision of adequate and appropriate training and validation of competency skills: ☐ Yes ☐ No

d) the arrangement of supervision is in place under the appropriate management: ☐ Yes ☐ No

If you answered no to a), b), c) or d) above, please explain why not:

2.17 Please state if you operate, in whole or in part, as an NHS Independent Treatment Centre or undertake any work for the NHS for which you require cover under this insurance? ☐ Yes ☐ No

If yes, please provide full details including the annual revenue generated from this work:

2.18 Please state whether you sub-contract any work: ☐ Yes ☐ No

If yes, please provide full details of the nature of the sub-contracted work, including any one-off projects:

If you answered yes to 2.16, please state whether all sub-contractors maintain their own medical liability insurance with a limit of liability that is no less than the limit of liability maintained by you and whether the sub-contractors provide evidence of the insurance that is in force: ☐ Yes ☐ No

If no, please explain why not:

2.19 Please state whether you enter into any written agreements or whether you operate under a standard form of contract or letter of appointment: ☐ Yes ☐ No

If yes, please provide a copy.

2.20 Please state whether there are facilities at the business premises for the sterilisation of instruments in accordance with current guidelines and whether cross infection control procedures are adhered to: ☐ Yes ☐ No

If no, please explain why not:

2.21 Please state whether the current guidelines for the safe collection and disposal of any clinical or medical waste products are complied with: ☐ Yes ☐ No

If no, please explain why not:

2.22 Please state whether you have a protocol in place for needle-stick injuries? ☐ Yes ☐ No

If no, please explain why not:

2.23 Please state whether you have been, are currently involved in or are planning any clinical trials which you require cover for? ☐ Yes ☐ No

If yes, please provide full details:

2.24 Please state whether you are registered as a data controller under the Data Protection Act: ☐ Yes ☐ No

If you hold personally identifiable data on electronic systems it must be registered with the Information Commissioners Office.

Please state the following in respect of electronic data held on patients or clients:

a) anti virus software is installed and enabled on all IT equipment, including desktops, laptops and servers (excluding database servers) that it is updated on a regular basis: ☐ Yes ☐ No

b) firewalls are installed on all external gateways: ☐ Yes ☐ No

c) regular back-ups (at least weekly) are taken of all critical data and stored offsite or in a fire-proof safe or any outsourced service provider meets this requirement: ☐ Yes ☐ No

2.24 Is there any other information that you think should be disclosed to us for which cover is required? ☐ Yes ☐ No

If yes, please provide details, for example, any part time activities or details of associated companies:

2.25 In your opinion, which of your business activities are likely to give rise to a claim against you?

SECTION 3 : CLAIMS EXPERIENCE

Please answer the following questions. Please consider all relevant information and if in doubt, refer to your broker. Regarding all types of insurance to which this application form applies:

After full enquiry:

a) i. has any claim, complaint or allegation of negligence been made against you during the last 10 years (even if there was a favourable outcome)? ☐ Yes ☐ No

ii. has there been any form of disciplinary action or investigation for professional misconduct? ☐ Yes ☐ No

iii. has there been any statutory sanction against you: ☐ Yes ☐ No

iv.have you ever been subject to any adverse findings, conditions, suspension or erasure by a regulator, registration body or equivalent? ☐ Yes ☐ No

b) is there any incident or circumstance which may lead to any claim, complaint or allegation of negligence or disciplinary action or investigation? ☐ Yes ☐ No

c) has there been a loss of data that has resulted in a privacy breach? ☐ Yes ☐ No

d) has any insurer ever declined to insure you, imposed any special terms, cancelled or declined to renew your insurance? ☐ Yes ☐ No

If the answer to any of the above is yes, then please attach full details including an explanation of the background of events, all relevant dates, the status of the claims or circumstances, the maximum amount involved or claimed and any reserves or payments made.

SECTION 4 : INDEMNITY HISTORY & REQUIREMENTS

4.1 Please provide details of your current and previous indemnity arrangements and what you now require for this insurance:

	Retroactive date	Effective date	Limit	Deductible	Premium	Insurer
Previous:	MM / YY	MM / YY				
Previous:	MM / YY	MM / YY				
Previous:	MM / YY	MM / YY				
Current:	MM / YY	MM / YY				

	Retroactive date	Effective date	Limit	Deductible
Now Required:	MM / YY	MM / YY		

4.2 Please indicate below if you would like any of the following covers included in addition to your Medical Malpractice quote:

Professional Indemnity: ☐ General Liability ☐ Employers' Liability ☐

Cyber Liability: ☐ Legal Expenses Insurance: ☐

SECTION 5 : DECLARATION

I declare that:

after full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;

I will inform you before cover incepts of any change to the information supplied by me; and

I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Full name: _____ Signed: _____

Position held at Insured: _____ Date: _____ DD / MM / YY

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Συγκατάθεση για τη χρήση πληροφοριών

Η General Cover insurance Brokers θα χρησιμοποιήσει τις πληροφορίες που παρέχονται στο παρόν για τη διαχείριση του ασφαλιστηρίου συμβολαίου, συμπεριλαμβανομένων των αναδοχών και των απαιτήσεων Χειρισμός, ή Αντιμετώπιση. Αυτό μπορεί να περιλαμβάνει τη γνωστοποίησή του σε άλλους ασφαλιστές, ρυθμιστικές αρχές ή στους πράκτορες του ασφαλιστή για λογαριασμό τους.
Ο ασφαλιστής μπορεί να παράσχει, κατόπιν αιτήματος, περισσότερες λεπτομέρειες μέσω των βάσεων δεδομένων στις οποίες έχει πρόσβαση ή συνεισφέρει .

Δήλωση

Ο κάτωθι υπογεγραμμένος επιβεβαιώνω ότι είμαι δεόντως εξουσιοδοτημένος και δίνω συγκατάθεση για τη χρήση των πληροφοριών όπως ορίζεται ανωτέρω .
Επίσης δηλώνω ότι είμαι εξουσιοδοτημένος να ολοκληρώσω αυτήν την πρόταση εξ ονόματος του προτείνοντος. Αναλαμβάνω να ενημερώσω τον ασφαλιστή για οποιασδήποτε ουσιώδη τροποποίηση ή προσθήκη σε αυτές τις δηλώσεις ή στοιχεία που εμφανίζονται πριν από την έναρξη της περιόδου ασφάλισης. Αναγνωρίζεται και συμφωνείται ότι οι όροι υπόκεινται σε περιορισμούς και οι εξαιρέσεις από την πολιτική ενδέχεται να υποστούν αλλαγές οποιαδήποτε στιγμή πριν από την έναρξη της περιόδου ασφάλισης αν θα πρέπει να προκύψουν τέτοιες υλικές τροποποιήσεις ή προσθήκες. Η υπογραφή αυτής της πρότασης δεν δεσμεύει τον ασφαλιστή να δώσει προσφορά, ούτε ο αιτών να δεχθεί την ασφάλιση.

Υπογραφή *

Όνομα

Θέση της εταιρείας

Ημερομηνία

* ο υπογράφων θα πρέπει να είναι διευθυντής ή ανώτερος υπάλληλος της εταιρείας ή ο ασφαλιζόμενος

ADDITIONAL INFORMATION:

DOCTORS LIST

No	SURNAME	NAME	DATE OF BIRTH	SPECIALISATION	YEARS OF PRACTICING	CLAIMS
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2						
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