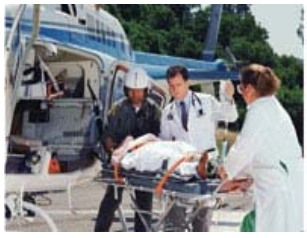
Marketform

Medical Malpractice Insurance

International

Proposal Form B
Non-Hospital Medical/Surgical Providers

- *Aesthetic Treatment Clinics*
- *Ambulance Services*
- *Clinical Research Establishments*
- *Complementary Medical Facilities*
- *Diagnostic Imaging Facilities*
- *Drug Testing Centres*
- *Emergency / Urgent Care Centres*
- *First Aid / Paramedic Group*
- *Home Health Services*
- *Hospices*
- *Industrial / Occupational Health*
- *Medical Employment Agencies*
- *Nursing and Residential Care Homes*
- *Outpatient Surgery Centres*
- *Pathology Labs*
- *Primary Care Clinics*
- *Rehabilitation Centres*
- *Repatriation Services / Air Ambulance*
- *Specialty Care Clinics*
- *Telemedicine*



MEMBER OF
GREAT AMERICAN INSURANCE GROUP

LLOYD'S
Underwriters

GENERAL GUIDANCE

This Proposal Form is for a CLAIMS MADE policy. A CLAIMS MADE policy only responds to claims made against the Assured and notified to Underwriters during the period of insurance arising from treatment provided on or after the policy RETROACTIVE DATE. This Proposal Form can be completed electronically or by hand and must be signed and dated by an authorised representative of the Assured. 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.

Upon acceptance of the Underwriter's terms and conditions and payment of the premium, all information provided by the Proposer together with the guidance notes will be deemed to be incorporated in the contract between Underwriters and the Assured.

Please ensure you have signed and dated the warranty statement at the end of this proposal form

SECTION 1 - GENERAL INFORMATION

1.1 Name of Organisation

a) Trading Name *(if different)*

1.2. Principal Trading Address

Registered Address *(if different)*

*For additional locations please complete **Addendum 1** – additional locations and addresses*

1.3 a) Date Established DD/MM/YYYY

c) Website

b) Contact Tel

d) Contact Email

1.4 Type of Organisation *(Please enter best description if not shown in list)* Please Choose

1.5 Tax Status ◯ For Profit ◯ Not For Profit ◯ Public ◯ Government Entity

1.6 Please list the associations,professional bodies and regulatory organisations 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 - FINANCIAL INFORMATION

2.1 Please provide the following information for the past, current and future financial years:

	Past Financial Year	Current Financial Year	Next Year (Estimate)
Gross Revenue			
Operating Profit/Loss			
Net Cash			

SECTION 3 - PROFESSIONAL SERVICE

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

Please attach any relevant supporting literature including marketing brochures / press releases pertinent to the business.
THIS COVERAGE WILL ONLY APPLY TO PROFESSIONAL SERVICES AS DESCRIBED HERE AND IN ANY ADDITIONAL PAGES SO PLEASE BE THOROUGH IN THE DESCRIPTION OF YOUR BUSINESS.

SECTION 4 - EXPOSURE INFORMATION

Please complete the following tables as completely as possible with the most up to date information available.
If possible complete the information applicable to the policy period for which cover is sought.

4.1 Do you have inpatient facilities? ◯ Yes *- Please complete Table below* ◯ No

a) Please complete the following with the total number of each type of **inpatient bed** and the approximate percentage occupancy during each year.

Bed Count	Past Year	Occupancy %	Current Year	Occupancy %	Next Year	Occupancy %
Adult						
Child						
Elderly						
Other (please specify)						
Other (please specify)						

b) Please complete the following table, specifying each type of patient visit undertaken by your organisation

Patient Visit Type	Past Year	Current Year	Next Year
Please specify type			
Please specify type			
Please specify type			
Please specify type			
Please specify type			
Please specify type			

If you are able to give additional years of exposure information please complete ***Addendum 2***

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

SECTION 5 - MEDICAL STAFF

5.1 Please complete details of your medical staff, clearly identifying those for which coverage under this insurance is sought.

Doctors	*Employed*		*Non-Employed*		***Other Medical Staff***	*Employed*		*Non-Employed*	
Coverage Required?	*Yes*	*No*	*Yes*	*No*	*Coverage Required?*	*Yes*	*No*	*Yes*	*No*
General Practitioners					Dentists				
Psychiatrists					Registered Nurses				
Radiologists					Nurse Practitioners				
Obstertricians					Midwives				
Gynaecologists					Nurse Anaesthetists				
Anaesthetics					Lab Technicians				
General Surgeons					Paramedics				
Orthopaedic Surgeons					Complementary				
Cosmetic Surgeons					Pharmacists				
Trainee Doctors					Other (please specify)				
Opthalmology					Other (please specify)				
Other (please specify)					Other (please specify)				
Other (please specify)					Other (please specify)				

Please complete the above table using Full Time Equivalents (FTE). An FTE is equivalent to a 40 hr week, on an annual basis

5.2 Have the numbers of medical staff changed significantly over the past 5 years? ◯ Yes ◯ No
- If Yes please provide details by completing Addendum 3

5.3 Do you require that all professionally qualified medical staff:

a) Are registered with or licensed by the relevant government regulatory body or licensing and registration body? ◯ Yes ◯ No

b) Are adequately trained and competent for their role? ◯ Yes ◯ No

c) Are adequately supervised under the appropriate management? ◯ Yes ◯ No

d) Are re-credentialed on at least an annual basis? ◯ Yes ◯ No

- If No, how often are medical staff members re-credentialed?

5.4 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 ◯ No *- If Yes please specify the limits required:*

b) Provide evidence of this coverage on an annual basis? ◯ Yes ◯ No

SECTION 6 - RISK MANAGEMENT & QUALITY ASSURANCE

6.1 Staff member responsible for risk management:

Name: Position:

6.2 Do you have a documented risk management programme? *- If Yes please attach details* ◯ Yes ◯ No

6.3 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

6.4 Do you comply with the current guidelines for the safe collection & disposal of any clinical/medical waste products? ◯ Yes ◯ No

6.5 Are your Medical Records ◯ Written ◯ Electronic

6.6 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 and in the case of a patient with mental incapacity, indefinitely.

6.7 Is informed consent obtained from each patient and documented in the medical record? ◯ Yes ◯ No

If No, how often is informed consent obtained?

6.8 Do you have a formal programme for clinical quality assurance? *- If Yes please attach details* ◯ Yes ◯ No

6.9 Please comment below on how clinical quality is maintained in line with best practice within your industry and how this is benchmarked against your peers:

SECTION 7 - INCIDENTS, COMPLAINTS & CLAIMS

7.1 Do you have a written procedure for the reporting of incidents and adverse events? ◯ Yes ◯ No
- If Yes please attach details

7.2 Do you have a complaints manager and a written procedure for the handling of patient complaints? ◯ Yes ◯ No
- If Yes please attach details

7.3 Do you currently manage claims in-house? ◯ Yes ◯ No

7.4 During the last 10 years has any claim been made, defended or settled, or has any malpractice or negligence been alleged against you? ◯ Yes ◯ No

7.5 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

7.6 Has any Partner, Principal or Director or member of staff ever been subject to Disciplinary Proceedings for professional misconduct? ◯ Yes ◯ No

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.

7.7 If you have answered "Yes" to any of the above, please provide full details below complete information on all claims and circumstances, including full financial details. Please also provide dated copies of the claims sheets from any previous insurers.

Claim Status	Claimant / Claim No.	Incident Date	Date of Complaint	Incurred Indemnity	Incurred Expenses	Description
		DD/MM/YYYY	DD/MM/YYYY			
		DD/MM/YYYY	DD/MM/YYYY			
		DD/MM/YYYY	DD/MM/YYYY			
		DD/MM/YYYY	DD/MM/YYYY			
		DD/MM/YYYY	DD/MM/YYYY			

*For additional space and for definitions of the above terminology please complete **Addendum 4**.*

7.8 Please provide details of any third party administrator, loss adjustor or legal firm who you currently use in the handling of your claims.

SECTION 8 - MEDICAL PROFESSIONAL LIABILITY COVERAGE REQUIREMENTS

8.1 Please advise the first day that cover is required DD/MM/YYYY

8.2 Please provide full details of your medical professional liability cover for the past 5 years:

Year	Insurer	Period of Cover	Limit of Indemnity	Excess	Premium
2013					
2012					
2011					
2010					
2009					

8.3 Has prior cover been on a CLAIMS MADE basis? ◯ Yes ◯ No

a) If Yes, what is the current retroactive date? DD/MM/YYYY

8.4 Please provide details of coverage requested:

a) Limit of Indemnity:

b) Excess:

8.5 Has any proposal for similar insurance 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:

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

8.7 Describe any statutory, legal or administrative provision which might serve to limit or otherwise affect the institution's liability or loss exposure (e.g. statutory caps on damages, tort reform etc.)

8.8 Please outline any further information that you believe may affect Underwriters' consideration of the risk.

SECTION 9 - 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 form does not bind the proposer to complete this insurance, however a fully signed and dated proposal form will be required prior to binding the insurance.

Signature of authorised Individual/Partner/Principal/Director:

Signature:	Date:
	DD/MM/YYYY

Print Name:	
Position:	
Phone:	
Email:	

SECTION 10 - SUPPLEMENTARY INFORMATION

PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE APPROPRIATE QUESTION NUMBER.