RenaissanceRe
Syndicate 1458

Medical Malpractice Liability Insurance Proposal Form

RenaissanceRe

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Medical Malpractice Liability Insurance Proposal Form

Guidance and Important Notices

THESE NOTICES APPLY TO THIS PROPOSAL AND ANY ATTACHED ADDENDA

These guidance notes explain about the duties of disclosure required in completing this Proposal and some of the more important aspects of the insurance contract. This Proposal uses certain terms defined within the corresponding policy wording which should be read in conjunction with this Proposal.

Proposal Form

This Proposal must be typed or completed in ink and signed and dated by the Proposer or an authorised representative of the Proposer. Every question must be answered accurately and fully. NONE or NOT APPLICABLE should be entered if any questions do not relate to the Insured.

In the event of any conflict between the Proposal and the policy, the policy shall prevail.

"Claims Made" and Prior Claims

This is a proposal for a "Claims Made and Reported" policy. A "Claims Made and Reported" policy only provides cover in respect of Claims made against the Insured and notified to Underwriters during the Policy Period and/or any discovery period. The Underwriters shall not be liable for any Claim or Defence Costs that the Insured knew about or reasonably could have forseen or discovered prior to the Policy Period or a stipulated retroactive date. For example, where any Insured has received either an oral or written communication from or on behalf of a patient, the Insured will be deemed to have been aware of a Claim. In addition, the Underwriters shall not be liable for any Claim or Defence Costs arising from any circumstance, occurrence, fact, matter or Claim notified to any insurer and/or medical defence organisation prior to the Policy Period, or arising from any circumstance, occurrence, fact, matter or Claim existing or happening prior to any stipulated retroactive date.

Material Facts

The Underwriters will rely upon the material facts and information supplied in the Proposal and therefore it is important that: (a) all Medical Services for which cover is required and (b) every matter which is known or ought reasonably to be known by the Insured and that a reasonable person in the circumstances could be expected to identify as relevant and/or material to the risk being insured are disclosed in the Proposal before this policy is entered into and at any renewal, extension, variation or reinstatement of the policy.

In the event of any material changes during the Policy Period, such as expansion, addition of new services or locations, merger, sale or take-over, it is important that these material changes are notified to the Underwriters immediately in writing, as these changes will affect the coverage provided by this policy.

LLOYD'S Underwriters

RenaissanceRe Syndicate 1458: Medical Malpractice Liability Insurance Proposal Form

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SECTION 1 – GENERAL INFORMATION

Please provide the following information about the Insured as a corporate entity:

1. (a) The Insured's full name:

(b) The Insured's trading name (if different):

(c) How long have you been trading under the above name?

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2. Have you ever carried out medical services under a different name? ☐ **YES** ☐ **NO**

If "**YES**", then give full details here:

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3. (a) Who is the Insured's ultimate owner or holding company?

(b) List any corporate or private entity of USA or Canadian origin with any ownership or interest in the Insured or the Insured's ultimate owner or holding company:

(c) How long has your current operation been managed or owned by the present parent/owner?

(d) Please give details of the Insured's registered office:

(e) Please give details of the Insured's trading address(es):

(f) Do any of your activities involve a joint venture with any other company, partnership, individual or other professional grouping? ☐ **YES** ☐ **NO**

If "**YES**", then give full details here:

(g) Will your activities involve new or incoming partners becoming involved in your activities during the next 12 months? ☐ **YES** ☐ **NO**

If "**YES**", then give full details here:

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4. (a) In respect of medical services at the addresses specified above, are you in posession of the relevant licences and/or registrations from the applicable regulatory body or as required by law? ☐ **YES** ☐ **NO**

If "**NO**", then give full details here:

(b) Which associations, professional bodies or self-regulatory organisations is the Insured a member of or registered with?

(c) Has membership or registration with any such bodies or organisations in the past been suspended or withdrawn, had conditions imposed on it, or an application for it declined? ☐ **YES** ☐ **NO**

If "**YES**", then give full details here:

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5. (a) What is your total ☐ gross fee income, ☐ turnover or ☐ gross receipts (please tick appropriate box)? Currency:

(i) For the last complete financial year:

(ii) Estimate for the current financial year:

(iii) Estimate for the next financial year:

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6. (a) What percentage of funding is derived from the following:

(i) Government or public funds?

(ii) Private funding?

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7. (a) Are there any discussed or proposed changes in your activities or any major developments likely to occur within the next 12 months? ☐ **YES** ☐ **NO**

If "**YES**", then give full details here:

(b) Has the exposure relating to this proposal changed materially over the last five years? (e.g. Have there been material changes in the number of beds, procedures carried out, or doctors employed or other significant changes in the risk?) ☐ **YES** ☐ **NO**

If "**YES**", then please provide full details in a separate table or spreadsheet.

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8. (a) Do you have any subsidiary companies for which cover is also required? ☐ **YES** ☐ **NO**

If "**YES**", then give full details in a separate proposal. (See Section 8)

SECTION 2 – MEDICAL SERVICES

1. (a) Does the Insured have any in-patient facilities? ☐ **YES** ☐ **NO**

If "**NO**", then continue from Question 3 onwards.

(b) Total beds now and average daily occupancy over last 12 months:

	NUMBER	AVERAGE DAILY %
Acute Care Beds		
General Beds		
Psychiatric Beds		
Bassinets, Cribs and Cots		
I.C.U./I.T.U. Beds		
N.I.C.U.		
TOTAL		

(c) Total number of in-patients:

(i) Last complete financial year:

(ii) Current financial year (estimate):

(iii) Next financial year (estimate):

(iv) Proportion of in-patients coming from the following territories (last complete financial year):

	%
USA	
Canada	

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2. (a) Number of in-patients admitted during the last 12 months:

	NUMBER OF IN-PATIENTS ADMITTED	%
Bariatric Surgery		
Drug/Alcohol		
Dental/Maxillofacial		
Elective Cosmetic		
Elective Termination of Pregnancy		
Gender Reassignment		
Gynaecology		
Paediatric		
Psychiatric		
Infectious Diseases		
Minor Surgery		
Intermediate Surgery		
Major Surgery		

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3. (a) Please provide information about procedures performed at any out-patient clinic(s) **NOT** included in the above information or set out in a separate proposal (Section 8).

	NUMBER OF OUT-PATIENTS TREATED	% OF GROSS FEE INCOME, TURNOVER, AND/OR GROSS RECEIPTS
Accidental and Emergency		
Antenatal		
Assisted Conception		
Dental		
Dialysis		
Elective Cosmetic		
Elective Termination of Pregnancy		
HIV_HEP		
Laser Eye Surgery		
Nutrition		
Pathology		
Radiology/MRI/CAT Scan/X-Ray		
STD		
Sports Injury		
Well Man/Well Woman		
Other		

4. (a) Do you operate any road or air ambulance services? ☐ **YES** ☐ **NO**

If "**NO**", please go to Question 5.

(b) Are the ambulances used for:

(i) Patient Transfers? ☐ **YES** ☐ **NO**

(ii) First Response? ☐ **YES** ☐ **NO**

(iii) Both? ☐ **YES** ☐ **NO**

(c) Number of road ambulances owned or operated:

(d) Number of air ambulances owned or operated:

(e) Number of emergency movements during the last 12 months:

(f) Number of non-emergency movements during the last 12 months:

(g) Please list the countries outside your domicile in which you operate ambulance services:

5. (a) Do you use nurse anaesthetists? ☐ YES ☐ NO

If "**NO**", proceed to Question 6.

(b) Do you ensure they carry individual professional liability cover? ☐ YES ☐ NO

(c) Are nurse anaesthetists supervised by a fully qualified anaesthesiologist at all times during procedures? ☐ YES ☐ NO

(d) Do you have a fully qualified anaesthesiologist available on site at all times? ☐ YES ☐ NO

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6. (a) Do you have a blood bank? ☐ YES ☐ NO

If "**NO**", please go to Question 7.

(b) Are all blood products purchased from National Blood Transfusion Service or National Red Cross? ☐ YES ☐ NO

If "**NO**", please provide details:

(c) Average number of units of blood and blood products used per month in last 12 months:

(d) Do you outsource any of your blood products? ☐ YES ☐ NO

(e) Do you test all blood or blood products for transmittable or infectious diseases according to the current guidelines from your National Blood Transfusion Services, National Red Cross or equivalent licensing body prior to use? ☐ YES ☐ NO

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7. (a) Do you undertake assisted conception (IVF) services? ☐ YES ☐ NO

If "**NO**", proceed to Question 8.

(b) Is all donor semen screened, cryopreserved and quarantined in accordance with current HFEA or similar regulatory organisation guidelines or code of practice? ☐ YES ☐ NO

(c) Do you undertake pre-implantation genetic diagnosis? ☐ YES ☐ NO

If "**YES**", how many tests were undertaken during the last 12 months?

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8. (a) Do you undertake bariatric surgery? ☐ YES ☐ NO

If "**NO**", proceed to Question 9.

(b) Please provide the types of procedures undertaken during the last 12 months:

(c) Do you offer these services to patients under 18 years old? ☐ YES ☐ NO

(d) Do you always obtain informed consent from patients prior to performing bariatric procedures? ☐ YES ☐ NO

If "**YES**", please provide a copy of the template form.

(e) Do you use criteria to exclude patients? ☐ YES ☐ NO

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9. (a) Do you undertake clinical trials? ☐ **YES** ☐ **NO**

If "**NO**", proceed to Question 10.

(b) Please provide full details of all clinical trials active during the last 12 months, stating the type, duration, number of participants and multi-site sponsor/prinicpals indemnity:

(c) Do all trial participants sign an informed consent form prior to participation in the trial? ☐ **YES** ☐ **NO**

(d) Is each prospective trial subject to a full risk analysis and sign off by your organisation's ethics committee? ☐ **YES** ☐ **NO**

(e) Do you conduct any formal research, testing or experimental activities in the following categories:

(i) Transplant? ☐ **YES** ☐ **NO**

(ii) Human Embryo? ☐ **YES** ☐ **NO**

(iii) Surgery? ☐ **YES** ☐ **NO**

(iv) Artificial Organ? ☐ **YES** ☐ **NO**

(v) Obstetric? ☐ **YES** ☐ **NO**

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10. (a) Do you undertake emergency services? ☐ **YES** ☐ **NO**

If "**NO**", proceed to Question 11.

(b) Do you provide 24/7 attending emergency medicine physician/registrar cover? ☐ **YES** ☐ **NO**

(c) Please give details of the "triage" policy you have in place:

(d) Do any of the emergency department staff routinely work more than a 12-hour shift? ☐ **YES** ☐ **NO**

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11. (a) Do you undertake obstetrics procedures? ☐ **YES** ☐ **NO**

If "**NO**", proceed to Question 12.

(b) Please provide details of the number of deliveries per annum in the following categories:

	NUMBER OF PATIENTS	
	Current Financial Year	Previous Complete Financial Year
Vaginal		
Caesarean		
Vaginal Birth after Caesarean		

(c) Is an attending obstetrician required to review foetal monitoring readings periodically during labour or delivery? ☐ **YES** ☐ **NO**

(d) Is continuous electronic foetal monitoring performed for all patients in active labour? ☐ **YES** ☐ **NO**

(e) Is an attending obstetrician required to approve the use of oxytoxic drugs during labour? ☐ **YES** ☐ **NO**

(f) Can midwives perform deliveries other than uncomplicated normal deliveries without an obstetrician being present? ☐ **YES** ☐ **NO**

(g) Is an obstetrician available in-house 24-hours per day? ☐ **YES** ☐ **NO**

(h) Can caesarean sections be performed within 30 minutes 24-hours per day? ☐ **YES** ☐ **NO**

(i) Are any deliveries performed outside the hospital? ☐ **YES** ☐ **NO**

(j) Do you provide NICU services for other hospitals? ☐ **YES** ☐ **NO**

If "**YES**", how many during the last 12 months?

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12. (a) Do you provide pharmacy services? ☐ **YES** ☐ **NO**

If "**NO**", proceed to Question 13.

(b) Do you provide pharmacy services to other organisations? ☐ **YES** ☐ **NO**

If "**YES**", please provide details:

(c) Do you have written procedures for pharmacy safety control? ☐ **YES** ☐ **NO**

(d) Do you utilise electronic medication management (bar-coding)? ☐ **YES** ☐ **NO**

(e) Do you have a pharmacist on-site 24/7? ☐ **YES** ☐ **NO**

(f) Are you in compliance with all applicable regulatory laws or ordinances governing the manufacture, dispensing and distribution of drugs? ☐ **YES** ☐ **NO**

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13. (a) Do you undertake surgical procedures? ☐ **YES** ☐ **NO**

If "**NO**", proceed to Question 14.

(b) Is the hospital/institution a regional referral centre for any surgical services? ☐ **YES** ☐ **NO**

(c) Can a house officer or resident perform surgery without an attending surgeon being present? ☐ **YES** ☐ **NO**

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14. (a) Do you undertake transplant procedures? ☐ **YES** ☐ **NO**

If "**NO**", please go to Question15.

(b) Please provide details of the transplant types undertaken:

(c) Please confirm you are fully accredited by the relevant regulatory body: ☐ **YES** ☐ **NO**

(d) Do you accept presumed consent (opt-out) donors? ☐ **YES** ☐ **NO**

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15. (a) Do you undertake telemedicine services? ☐ **YES** ☐ **NO**

If "**NO**", proceed to Section 3.

(b) Do you provide primary (doctor to patient) or secondary (doctor to doctor review) telemedicine?

(i) Primary: ☐ **YES** ☐ **NO**

(ii) Secondary: ☐ **YES** ☐ **NO**

(iii) Both: ☐ **YES** ☐ **NO**

(c) Please list the countries outside your domicile in which you practice telemedicine:

(d) How many telemedicine encounters do you average per year?

(e) Do all providers use standardized clinical protocols when conducting telemedical interviews? ☐ **YES** ☐ **NO**

(f) Do you:

(i) Confirm the existence of appropriate liability coverage? ☐ **YES** ☐ **NO**

(ii) Request indemnity – from any institutions to whom you provide secondary telemedicine services? ☐ **YES** ☐ **NO**

SECTION 3 – MEDICAL STAFF

1. (a) Number of employed and non-employed medical staff:
If completing the "other surgeon" or "other Physician" categories, please specify the specialty or board certification.

	NUMBER OF MEDICAL STAFF	
	Employed	Non-employed
Allergy		
Acute Medicine/Hospitalist		
Anaesthesiology		
Bariatric Surgery		
Cardiovascular Disease		
Chiropractor		
Colorectal Surgery		
Complimentary Practitioners		
Counsellors		
Dental/Maxillofacial Surgeon		
Dentist		
Dermatology		
Elective Cosmetic Surgery		
Emergency Medicine		
Endocrinology incl. Diabetology		
ENT		
Gastroenterology		
General Surgeon		
General Practice		
Gynaecologist		
Haemotology		
Infectious Diseases		
Intensivist/Critical Care		
Lab/Path Tech		
Midwifery		
Neonatology		
Nephrology		
Neuro Surgery		
Neurology		
Nurse Anaesthetist		
Nurse Day		
Nurse Night		
Nurse Practitioner		
Obstetrician		
Occupational Medicine		
Oncology		
Ophthalmologist		
Orthopaedic Surgeon		
Other Physician		

1. (a) Number of employed and non-employed medical staff: (continued)
If completing the "other surgeon" or "other Physician" categories, please specify the specialty or board certification.

	NUMBER OF MEDICAL STAFF	
	Employed	Non-employed
Other Surgeon		
Nuclear Medicine		
Paediatrics		
Paramedics		
Pathology		
Pharmacists		
Physiotherapy		
Physician Assistant		
Podiatrist		
Psychiatrists		
Radiology/MRI/CAT Scan/X-Ray		
RMO		
Supplementary Professionals		
Thoracic Surgeon		
Urology		
Vascular Surgeon		

(b) Do you require that all professionally qualified medical staff:

(i) Are registered with or licensed by the relevant government regulatory body or licensing and registration body? ☐ **YES** ☐ **NO**

(ii) Are adequately trained and competent for their role? ☐ **YES** ☐ **NO**

(iii) Are adequately supervised under the appropriate management? ☐ **YES** ☐ **NO**

(iv) Are re-credentialed on at least an annual basis? ☐ **YES** ☐ **NO**

If "**NO**", how often are medical staff members re-credentialed?

(c) Do you require that all non-employed medical staff:

(i) Carry their own medical professional liability insurance or maintain indemnity via a Medical Defence Organisation, Association or other arrangement? ☐ **YES** ☐ **NO**

If "**YES**", please specify the limits required:

(ii) Provide evidence of this coverage on an annual basis, as part of your practitioner credentialing process? ☐ **YES** ☐ **NO**

(d) During the last 10 years have any professional practitioners ever been subject to disciplinary proceedings for misconduct in professional matters? ☐ **YES** ☐ **NO**

(e) Has any professional practitioner presently employed or engaged by you ever been held by a court, tribunal or similar body to have committed an act of fraud or held to have been negligent? ☐ **YES** ☐ **NO**

(f) Has any professional practitioner or staff been found guilty of a breach of any statutory obligations, by-laws or regulations? ☐ **YES** ☐ **NO**

SECTION 4 – RECORDS AND RISK MANAGEMENT

1. (a) Do you have a documented risk management programme? ☐ **YES** ☐ **NO**

(b) 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**

(c) Do you comply with the current guidelines for the safe collection and disposal of any clinical/medical waste products? ☐ **YES** ☐ **NO**

(d) Do you have a protocol for needlestick injuries? ☐ **YES** ☐ **NO**

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2. (a) Do you maintain and will you continue to maintain accurate descriptive records of all medical services and equipment used in procedures? ☐ **YES** ☐ **NO**

(b) In what format are these medical records stored in:

(i) Written? ☐ **YES** ☐ **NO**

(ii) Electronic? ☐ **YES** ☐ **NO**

(c) How long do you retain the records referred to above from the date of treatment and, in the case of a minor, after that minor attains majority?

(d) Do you maintain a record of all requests (whether written or oral) on behalf of patients for copies of medical records? ☐ **YES** ☐ **NO**

(e) Is informed consent obtained from each patient and documented in their medical record? ☐ **YES** ☐ **NO**

If "**NO**", please explain how often informed consent is obtained:

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3. (a) What measures are in place for the protection of sensitive information and compliance with relevant privacy legislation?

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4. (a) Do you have a formal programme for clinical quality assurance? ☐ **YES** ☐ **NO**

(b) Please provide details as to how clinical quality is maintained in line with best practice for the services you provide and how this is benchmarked against your peers:

(c) Please provide details of accreditation with industry regulatory, supervisory or accreditation bodies or organisations including dates of last and next accreditation:

SECTION 5 – INCIDENTS AND CLAIMS

1. (a) Do you have a written procedure for the reporting of incidents and adverse events? ☐ **YES** ☐ **NO**

If "**YES**", please provide details:

(b) Do you have a written procedure for the investigation of adverse events? ☐ **YES** ☐ **NO**

If "**YES**", please provide details:

(c) Do you have:

(i) A written procedure for the handling of patient complaints? ☐ **YES** ☐ **NO**

(ii) If "**YES**", do you have a dedicated complaints manager? ☐ **YES** ☐ **NO**

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2. (a) Do you have the capability to manage claims in-house? ☐ **YES** ☐ **NO**

If "**YES**", please provide details of current claims handling procedures:

If "**NO**", please provide details of any third party administrator, loss adjuster or legal firm who you currently use in the handling of your claims:

(b) 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**

2. (c) Are you aware of any circumstances which may result in a claim against you or any prior corporate practice, predecessors in business or any present or former partner, principle or director or professional practitioner? ☐ **YES** ☐ **NO**

(d) Has any partner, principal or director or member of staff ever been subject to disciplinary proceedings for professional misconduct? ☐ **YES** ☐ **NO**

If you answered "**YES**"to Questions 2a, 2b or 2c, please list all circumstances/claims over the last 10 years in a separate loss run in electronic spreadsheet format.

SECTION 6 – INSURANCE COVERAGE REQUIREMENTS

1. (a) Please advise the first day that cover is required or the expiry date of your existing policy:

(b) 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

(c) Has prior cover been on a claims made basis? ☐ **YES** ☐ **NO**

If "**YES**", what is the current retroactive date?

(d) Please provide details of coverage required:

(i) Limit of Indemnity:

(ii) Excess/Deductible:

2. (a) Has any proposal for similar insurance been made on behalf of the proposer's business, any predecessor of the business, or any partner, prinicpal, 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**

SECTION 7 – ADDITIONAL INFORMATION AND DECLARATION

Please outline any further information that you believe may affect underwriters' consideration of the risk:

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 undertake to inform Insurers of any material alteration to these facts occurring before completion of the contract of insurance. However, I/We agree 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 for the contract of insurance.

Signing this proposal form does not bind the proposer to complete this insurance.

Signature of authorised individual/partner/principal/director:

Signature: Date:

Print Name:

Position:

SECTION 8 – 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 1 – PUBLIC LIABILITY INSURANCE SECTION

1. (a) Do you require coverage for public liability Claims (including coverage for the provision of food and drink)? ☐ **YES** ☐ **NO**

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2. (a) Are all buildings owned or used by you in a good state of repair and regularly maintained? ☐ **YES** ☐ **NO**

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3. (a) Are the following regularly checked, serviced and repaired by fully qualified engineers?

(i) Air Conditioning Units: ☐ **YES** ☐ **NO**

(ii) Electricity Generators (including any Emergency Backup Generators): ☐ **YES** ☐ **NO**

(iii) Escalators: ☐ **YES** ☐ **NO**

(iv) Heating Systems and Boilers: ☐ **YES** ☐ **NO**

(v) Hoists: ☐ **YES** ☐ **NO**

(vi) Incinerators: ☐ **YES** ☐ **NO**

(vii) Lifts: ☐ **YES** ☐ **NO**

(viii) Water Tanks: ☐ **YES** ☐ **NO**

(ix) Sprinkler System: ☐ **YES** ☐ **NO**

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4. (a) Give details of premises functions or facilities which you subcontract here:

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5. (a) Do you ensure that all subcontractors carry their own insurance? ☐ **YES** ☐ **NO**

(b) Does such insurance include:

(i) Public liability insurance? ☐ **YES** ☐ **NO**

(ii) Workers' compensation insurance? ☐ **YES** ☐ **NO**

(iii) Do you require copies of these policies or inspect copies of these policies? ☐ **YES** ☐ **NO**

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6. (a) Do the premises comply with current fire precaution and prevention requirements? ☐ **YES** ☐ **NO**

(b) Are staff instructed in and kept regularly appraised on fire and emergency procedures? ☐ **YES** ☐ **NO**

(c) Is there an emergency electrical system? ☐ **YES** ☐ **NO**

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7. (a) Are there facilities for safe collection, storage and disposal, in accordance with current guidelines or legislationg of:

(i) Sharps? ☐ **YES** ☐ **NO**

(ii) Dressings, clinical and surgical waste, etc.? ☐ **YES** ☐ **NO**

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8. (a) Do you ensure that the following are safely disposed of, in accordance with current guidelines/legislation:

(i) Blood and blood products? ☐ **YES** ☐ **NO**

(ii) All other waste? ☐ **YES** ☐ **NO**

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9. (a) Do you require cover for liability arising from products? ☐ **YES** ☐ **NO**

If "**YES**", please provide details of products for which cover is required:

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10. (a) During the last 10 years has any claim been made, defended or settled or any negligence been alleged against you in relation to Public Liability? ☐ **YES** ☐ **NO**

If "**YES**", please list all circumstances/claims in a separate loss run in electronic spreadsheet format.
