TOTTEN GROUP
INSURANCE

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New Submissions: professionalliability@tottengroup.com Website: www.tottengroup.com

SPECIFIED SUPPLEMENTARY MEDICAL PRACTITIONERS APPLICATION

PLEASE NOTE This Medical Professional Liability Application Form is for a CLAIMS MADE policy except for Commercial General Liability Coverage (if required) will be on an OCCURRENCE FORM.

Underwriters will rely upon each and every response given in this Application Form and any Supplementary Application Form in deciding whether or not to insure this risk and if so at what premium, terms and conditions. Underwriters regard every response to be material to their decisions. Failing to answer or answering any question below incorrectly could invalidate any policy of insurance written by Underwriters for this risk.

We have a professional duty of confidentiality and are committed to holding personal information in strict confidence. The information provided to us will only be disclosed where required by law to do so or required to do so in conducting negotiations with third parties, such as insurance companies, on your behalf.

We will further safeguard the security of such information in a manner appropriate to sensitivity of that information.

BROKER/INSURANCE AGENT: _____

1. Full name of the Insured: _____

   Date of birth: _____

2. Trading name (if different from the above): _____

3. Have you ever engaged in a similar activity under a different name? ☐ Yes ☐ No

   If YES, please give full details: _____

4. a. Address: _____

   Postal Code: _____ Country: _____

   Telephone Number: _____ Fax Number: _____

   b. Practice/Trading address/es (if different from above): _____

   Postal Code: _____ Country: _____

   Telephone Number: _____ Fax Number: _____

   If cover is required for more than one location, please attach a list of all addresses.

5. a. Where did you graduate? _____ b. In what year? _____

   c. With what degree, diploma or designation? _____

   Please give details of any additional or post graduate qualifications: _____

6. In what capacity are you qualified or licensed to practice for which coverage is required?

☐ Audiologist	☐ Life Coach	☐ Pharmacist	☐ Speech Therapist
☐ Applied Behaviour Analysis	☐ Low Level Laser Therapy	☐ Physiotherapist	☐ Training Facilities
☐ Blood Collector	☐ Medical Lab Technician	☐ Podiatrist	
☐ Chiropodist	☐ Nurse	☐ Prosthetist/Orthotist	
☐ Dietician	☐ Nurse Anaesthetist	☐ Psychotherapy	
☐ First Aid Instructor	☐ Occupational Therapist	☐ Radiographer	
☐ First Aider	☐ PSW / Care Workers	☐ Rehabilitation Therapy	
☐ Healthcare Consultant	☐ Paramedic	☐ Sonographer	

☐ Other (please specify) _____

7. Please give full details of what patient records are kept, where and how they are stored and for how long they are retained:

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.

8. Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed:

	Employed	Self-Employed
The Applicant's Private Practice		
Public Sector Hospitals / Homes		
Private Surgical Hospitals / Homes		
Private Non-Surgical Homes		
Patients' Homes		
Other (please specify) _____		
Total		

If you are an employee, please state the name of the employing authority or the name of the private hospital or company for which you work: _____

9. **WHAT IS YOUR TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS?** (If new business please state estimated income for the forthcoming 12 months) _____

10. Please state the number of staff and give details of the capacity in which they practice: _____

11. a. Does the Applicant or any member of staff involved in the treatment or care of patients suffer from any disability, transmittable dieses i.e. Hepatitis, H.I.V. etc., or other impediment which may affect the performance of his or her professional duties or place patients at risk? ☐ Yes ☐ No

If 'YES' what procedures are in place? _____

b. Has the Applicant or any member of staff involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries? ☐ Yes ☐ No

If 'YES' please give full details: _____

12. a. Are you a member of any professional organization, or registered with any self regulating body? ☐ Yes ☐ No

If 'YES' please state which and period of membership/registration:

b. Has membership or registration with such organization/body ever been suspended, withdrawn, amended or declined or had conditions attached? ☐ Yes ☐ No

13. If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance? ☐ Yes ☐ No

If 'YES' please give full details: _____

14. Have you ever been Insured for Medical Professional Liability? ☐ Yes ☐ No

If 'YES' please state: a. The name of the Underwriter(s): _____

a. The Insurance period(s): _____

b. The limits of liability provided: _____

c. Has any application for this type of Insurance cover ever been:

a) declined? ☐ Yes ☐ No b) cancelled? ☐ Yes ☐ No c) required special terms? ☐ Yes ☐ No

If 'YES' please give full details: _____

_____

PREVIOUS CLAIMS HISTORY

15. a. List all claims made against the Applicant during the last 10 years. "**IF NONE, PLEASE STATE "NONE"**:

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the allegations and details of Claimant

b. List all circumstances/complaints which may give rise to a claim being made against the Applicant. **IF NONE, PLEASE STATE "NONE":**

Date of Circumstance/Complaint	Details including nature of the Complaint and details of the Complaint

16. a. Have all of the above in question 16 been notified to your previous Underwriters? ☐ Yes ☐ No

b. Have all of the above been accepted by your previous Underwriters? ☐ Yes ☐ No

17. Please indicate which limit(s) of indemnity you require quotations for:

☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000

LIABILITY INFORMATION - (Only complete this section if you also require a quote for Commercial General Liability)

Product Sales

Full Description of Product Sales	Gross Receipts (including subcontractors)		
	Estimate Next Year	Current Year	Prior Year

% U.S. _____ % Foreign _____ Details _____

Area of Operation: _____

Additional Locations List locations and occupations:

	Address	% occupied by Applicant		Square Footage	R/Cost of Rented Portion
1			☐ Owned		
			☐ Rented		
2			☐ Owned		
			☐ Rented		
3			☐ Owned		
			☐ Rented		
4			☐ Owned		
			☐ Rented		

Is Tenants Legal Liability required? ☐ Yes ☐ No

If Yes, state limits required for each location _____

Automobile

Provide details of unlicensed automobiles or specially licensed automobiles for which compulsory automobile insurance does not apply?

Is there an automobile policy covering these vehicles? ☐ Yes ☐ No

How many employees regularly drive their own vehicles on company business? _____

What is the cost of hired automobiles? _____

Aircraft Does the Insured do any work on airport premises? ☐ Yes ☐ No

Is there any aircraft exposure by way of ownership, maintenance, use or operation of any aircraft by or on behalf of the Applicant? ☐ Yes ☐ No

If yes, please describe _____

Watercraft

Is there any owned or non-owned watercraft exposure or ownership, maintenance, use or operation of any watercraft by or on behalf of the Applicant? ☐ Yes ☐ No

If yes, please describe _____

Contractual Obligations

Are there any known contractual obligations where the Applicant has to provide insurance on behalf of another or hold another harmless? If yes, please list all lease agreements, railway siding agreements, etc. & provide copies of agreements. ☐ Yes ☐ No

Are there any additional Insureds to be added to the policy? ☐ Yes ☐ No

If yes, list and state purpose:

Name	In Connection With

I/We declare and warrant that after enquiry all statements and particulars contained in the Application and addenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of the Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as practicable. I/We hereby agree and accept that this Declaration shall be that basis of the contract between both parties if entered into.

NAME OF PROPOSER _____

(IN BLOCK CAPITALS)

SIGNATURE _____ Dated _____

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