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MEDICAL ORGANIZATION HEALTH PROVIDERS APPLICATION

PLEASE NOTE This Medical Professional Liability Proposal 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 Proposal Form and any Supplementary Proposal 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. i) Full name of the Insured: ______________________________
   ii) Trading name (if different from the above): ______________________________
   iii) How long has the establishment been trading under the above name? ______________________________
2. Has the Insured or its principals engaged in any Healthcare activities under a different title in the last five years? If so, please provide details on a separate sheet identifying: Title, Trading and Registered Address, Nature of services.
3. i) Trading Address: ______________________________
   Postal Code: ______________________________ Country: ______________________________
   Telephone Number: ______________________________ Fax Number: ______________________________
   ii) Registered Office (if different from above): ______________________________
   Postal Code: ______________________________ Country: ______________________________
   Telephone Number: ______________________________ Fax Number: ______________________________
   NB: If cover is required for more than one location, please attach a list of all addresses.
4. i) Please name the ultimate Owner or Holding Company: ______________________________
   ii) Please identify any corporate or private entity of either USA or Canadian origin that has any ownership or interest in either the Insured or the Insured's ultimate owner or holding Company and their percentage holding.
   ____
   ____
   iii) Length of current operation by present Parent/Owner: ______________________________
   ____
5. i) Please state your total Gross Fee Income/ Turnover/ Gross Receipts:
   a) for the past Financial Year: ______________________________ b) estimate for the current Financial Year ______________________________
   ii) Please state the approximate number of patients/ clients:
   a) during your last Financial Year: ______________________________ b) during your current Financial Year ______________________________
6. i) **PLEASE GIVE A FULL DESCRIPTION OF YOUR BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (this must be answered)** ______________________________
   ____
   ____

7. ii) Please tick if your are involved in any of the following and where indicated*, complete the relevant Addendum.

	% total income
☐ Assisted Conception Unit *	________
☐ Autologous Bloodbank	________
☐ Clinical Research Establishment *	________
☐ Health & Fitness Centre/ Gym *	________
☐ Industrial/ Occupational Health & Safety *	________
☐ Inoculation/ Travel Centre	________
☐ Medical Personnel/ Employment Agency *	________
☐ Medical Teaching Facility	________
☐ Nursing Teaching Facility	________
☐ Pathology Laboratory *	________
☐ Repatriation &/or Ambulance Service *	________

iii) What, if any, substantial changes in your activities or major new developments are likely to occur within the next 12 months? Please give full details: ________________________________

____

8. i) Are you licensed and registered in accordance with the applicable regulatory body or law to practice those procedures at the address specified in Question 3 for which indemnification is required? ☐ Yes ☐ No

If 'NO' please give full explanation why not: ________________________________

____

____

ii) Please identify your memberships or registration with Association or Professional Bodies or Licensing Authorities.

____

____

iii) Has membership of or registration with such, ever been suspended, withdrawn, amended, declined or had conditions attached? ☐ Yes ☐ No

If 'YES' please give full details: ________________________________

____

PLEASE NOTE THAT THIS POLICY IS DESIGNED TO COVER CLAIMS MADE AGAINST THE INSURED. IF COVER IS ALSO REQUIRED FOR CLAIMS MADE AGAINST REGISTERED MEDICAL/DENTAL PRACTITIONERS FOR WORK PERFORMED FOR THE INSURED, PLEASE SUPPLY A LIST OF ALL SUCH PRACTITIONERS FOR WHOM COVERAGE IS REQUIRED STATING THE NAME, D.O.B., QUALIFICATIONS AND PRACTICE OF EACH PRACTITIONER IN ADDITION TO THIS PLEASE CONFIRM WHETHER OR NOT THE PRACTITIONERS ARE EMPLOYED BY THE INSURED OR SELF-EMPLOYED.

9. Do you ensure and record that at all times all Registered Medical and Dental Practitioners are members of a Medical/ Dental Defence Organization, recognized by your National Medical/ Dental Association, or are otherwise fully Insured for their own Malpractice? ☐ Yes ☐ No

If the answer is 'NO' please refer to the Note above.

10. Please state the total number of persons involved in the following capacities:

	Employed	Self-Employed
Non procedural Physicians:		
Psychiatrists		
Other		
Surgeons		
Cosmetic		
Orthopaedic		
Other		
Anaesthetists		
Obstetricians		
Gynaecologists		
Lab/Path technicians		
Dentists		
Midwives		
Nurse Anaesthetists		
Nurses – Day		
Nurses – Night		
Pharmacists		
Paramedics		
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries – Day		
Auxiliaries – Night		
Counsellors		
Directors/Partners/Principals		
Clerical/Administration		

Other (please specify) ______________________________

11. Are any counseling services made available to patients? ☐ Yes ☐ No

If 'Yes" i) Please indicate in which of the following categories:

	# of Counsellors	Employed	Self Employed	# of Patients
Assisted Conception				
Drug/Alcohol Dependency				
Elective Cosmetic				
Elective T.O.P.				
Gender Reassignment				
HIV/ HEP/ STD				
Sterilization				

Other (please specify): ______________________________

ii) Do all Counsellors hold appropriate qualifications? ☐ Yes ☐ No

Please provide details: ______________________________

____

12. Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e. Hepatitis, H.I.V. etc. or other impediment which may affect the performance of his/her professional duties or place patients/clients at risk? ☐ Yes ☐ No

If 'YES' what procedures are in place: ______________________________

13. i) Please state: Total number of Day Care Beds? ____________ Total number of Overnight beds: ____________

ii) Please state what, if any, percentage of patients/clients in the last year came from USE or Canada: ____________%

iii) Please state what, if any percentage of the patients/clients in the last year who may be resident in Britain come from USA or Canada ____________%

14. i) Do you provide facilities for the sterilization of instruments in accordance with current guidelines? ☐ Yes ☐ No

If 'NO' please provide details of what arrangements are in place for this: ______________________________

____

ii) Do you have a protocol for needlestick injuries? ☐ Yes ☐ No

If 'NO' please give full details: ______________________________

____

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

____

____

____

Please note that 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.

IF your require Public Liability Insurance please complete the following section:

PREMISES COVERAGE

16. Please give full details about the premises, including number of buildings and their age and any anticipated material developments:

i) Number of buildings? ____________

ii) Please give brief details of legislation that applies to the testing and servicing of water tanks, air conditioning units etc:

____

____

____

iii) Are lifts, hoists, escalators and the like regularly serviced under contract? ☐ Yes ☐ No

iv) a) What premises functions or facilities do you sub contract? ______________________________

____

____

____

b) What systems are in place to ensure that those sub contractors carry adequate insurance and name your organization as an additional Insured to their insurances?

____

____

____

17. i) Do the Premises comply with current precaution/prevention requirements? ☐ Yes ☐ No

If 'NO' give details: ______________________________

____

ii) Are staff instructed and kept regularly appraised In fire and emergency procedures? ☐ Yes ☐ No

iii) Do the premises have an emergency electrical system? ☐ Yes ☐ No

18. i) Do you provide facilities for safe collection, storage and disposal in accordance with current guidelines/ legislation of:

a) 'sharps'? ☐ Yes ☐ No

b) Dressings, clinical/ surgical waste etc? ☐ Yes ☐ No

ii) Do you ensure that the following are safely disposed of in accordance with current guidelines/legislation:

a) all blood/blood products? ☐ Yes ☐ No

b) all other waste? ☐ Yes ☐ No

PREVIOUS INSURANCE HISTORY

PLEASE REFER TO YOUR BROKER/INSURANCE AGENT IF YOU ARE IN DOUBT AS TO WHAT IS BEING ASKED OF YOU IN THIS SECTION

19. i) Who are the present Medical Professional and/or Public Liability Underwriters of the Insured?

____

____

ii) Has prior coverage been on a CLAIMS MADE BASIS? ☐ Yes ☐ No

iii) If 'YES' what is the retroactive date? ______________________________

____

iv) What are the present policy limits of insurance? ______________________________

v) What is the amount of self insured excess for each policy? ______________________________

vi) What is the expiry date of the present policies? ______________________________

20. Has any application for these type of insurance cover ever been:

i) declined? ☐ Yes ☐ No

ii) cancelled? ☐ Yes ☐ No

iii) required special terms? ☐ Yes ☐ No

If the answer to any of the above is 'YES' please give details: ______________________________

____

21. i) List all claims made against the Insured during the last 10 years for all Sections of cover requested,. **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

ii) List all circumstances/complaints which may give rise to a claim being made against the Insured for all Sections of cover requested. **IF NONE, PLEASE STATE "NONE":**

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

22. i) Have all of the above in question 20 been notified to your previous Underwriters: ☐ Yes ☐ No

ii) Have all of the above been accepted by your previous Underwriters? ☐ Yes ☐ No

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

☐ ¼ million ☐ ½ million ☐ 1 million ☐ 2 million Other please specify: ______________________

LIABILITY INFORMATION

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 Proposal 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.

ADDENDUM 1 – ASSISTED CONCEPTION

1. If an Assisted Conception unit is maintained, please give a full percentage breakdown of all procedures undertaken:

   A.I.H. ________ %

   A.I.D. ________ %

   I.V.F./E.T./P.R.O.S.T. ________ %

   Frozen Embryo Replacement ________ %

   G.I.F.T. ________ %

   Others (please specify and indicate percentage) ________

2. Is all donor semen screened cryopreserved and quarantined in line with current recommendations? ☐ Yes ☐ No

ADDENDUM 2 – CLINICAL RESEARCH

1. Please state for whom Clinical Research Projects are undertaken e.g. Pharmaceutical and other Manufacturers, Charities, Research Foundations ________
2. Do you receive a full indemnity from your Principals? ☐ Yes ☐ No
3. Do all volunteers sign an Informed Consent Form? ☐ Yes ☐ No
4. If Double Blind studies are undertaken are volunteers made fully aware of this? ☐ Yes ☐ No
5. Do any trials involve any female volunteers of child-bearing age? ☐ Yes ☐ No

   If 'YES' please provide full details: ________
6. Please state the Annual income or Turnover ________
7. Please state the number of trials during the last 12 months detailing the number of volunteers in each trial: ________
8. Please state the anticipated number of trials with which you will be involved during the next 12 months detailing the number of volunteers in each trial: ________
9. Do you conduct any formal research, testing or experimental activities in the following categories:

Transplant	Obstetrics	Genetic Engineering	
Surgery	Human Embryo Research	Artificial Organ	☐ Yes ☐ No

   If 'YES' please attach full details.

Please provide a copy of your Volunteer Informed Consent Form and any indemnity referred to in question 2 above.

ADDENDUM 3 – HEALTH & FITNESS CENTRES

1. Please state the approximate percentage of your income within the following categories:

   Gym/ Exercise ________ %

   Diet/ Nutrition ________ %

   Sunbeds/ Solarium ________ %

   Hairdressing ________ %

   Beauty Therapy ________ %

   Electrolysis ________ %

   Ear Piercing ________ %

   Other (please specify): ________
2. Please state the number and type of Complimentary Therapists ________

____

PLEASE ENCLOSE A COPY OF ANY OR ALL QUESTIONNAIRES THAT CLIENTS MUST COMPLETE PRIOR TO TREATMENT. IF THERE IS NONE, STATE "NONE". ________

ADDENDUM 4 – INDUSTRIAL/OCCUPATIONAL HEALTH

1. Is your work solely “in-house” i.e. limited to other divisions or companies with common ownership to yourselves? ☐ Yes ☐ No

   If ‘NO’ please give full details of other companies for whom work is undertaken: ______________________

   ____

2. Please give full details of any outpatient or other medical facilities made available to staff: ______________________

   ____

3. Is health screening made available? ☐ Yes ☐ No

IF ‘YES’ PLEASE COMPLETE THE FOLLOWING ADDENDUM:

ADDENDUM 5 – HEALTH SCREENING

1. Please give an approximate percentage breakdown of your patients between the following categories:
   - i) Insurance Medicals ______________ %
   - ii) General Fitness Assessment ______________ %
   - iii) Well Woman/Well Man ______________ %
   - iv) A.I.D.S. testing ______________ %
   - v) Other (please specify) ______________________________

2. Do you have C.A.T./ M.R.I. scanners or similar? ☐ Yes ☐ No

   If ‘YES’ please give details including date of purchase, details of any service contract or guarantee: ______________

   ____

ADDENDUM 6 – MEDICAL PERSONNEL AGENCIES

1. What are the minimum acceptable qualifications and years of experience in respect of the following?
   - i) Nurses
   - ii) Midwives
   - ii) Other (please specify): ______________________________

2. Are all staff vetted and references taken up? ☐ Yes ☐ No

   If ‘NO’ please give full details: ______________________________

3. Do you ensure that all nurses and midwives supplied by you maintain membership of the R.C.N. or the R.C.M. or are otherwise insured for Medical Professional Liability? ☐ Yes ☐ No

ADDENDUM 7 – PATHOLOGY LABORATORIES

1. Do you administer any pathology laboratories in medical establishments outside your ownership? ☐ Yes ☐ No

   If “YES’ please give full details:

2. What procedures are in place to ensure that results are promptly received by whom they were requested? ______________

   ____

3. Please give a percentage breakdown by income between the following:
   - i) Human Pathology ______________ %
   - ii) Animal Pathology ______________ %
   - iii) Drug Testing ______________ %
   - iv) Other: e.g. Legionnaires/Salmonella etc. (please specify and give full details): ______________ %

   ____

Within (i) above please confirm what percentage, if any, of your income/turnover/gross receipts is derived from A.I.D.S. testing. If none state “NONE”: ______________________ %

ADDENDUM 8 – REPATRIATION/ AMBULANCE SERVICES

1. Please state the
   i) Number of Ambulances in operation:
   ii) Number of crew members per Ambulance:
   iii) Minimum acceptable qualifications of crew members:
   iv) Average number of routine trips to hospitals, nursing homes etc. per annum:
   v) Average number of emergency calls per annum:
2. Is an Air Ambulance repatriation service maintained? If 'YES', please state: ☐ Yes ☐ No
   i) In which countries you anticipate operating: ____________________
   ii) The number of repatriations per annum: ____________________
3. Do you provide private Ambulance or First Aid at Public events? If 'YES' please give details of: ☐ Yes ☐ No
   i) The type and size of event for which services are provided: ____________________
   ii) The number of events per annum: ____________________