GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

A subsidiary of ONE80 INTERMEDIAIRES

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APPLICATION – **MEDICAL MALPRACTICE INSURANCE**

MEDICAL ESTABLISHMENT – MEDICAL PROFESSIONAL LIABILITY

Full Name of the Applicant: _____

Trading Name (if different from above): _____

How long has the Establishment been trading under the above name? _____

Has the applicant ever engaged in a similar activity under a different name?

☐ Yes ☐ No If Yes, please provide details: _____

Address: _____

_____

Phone: _____ Fax: _____ Email: _____

Website: _____

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

_____

Phone: _____ Fax: _____ Email: _____

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

1. OWNERSHIP

a) Please name the ultimate Owner or Holding Company:

_____

b) Please identify any corporate or private entity of USA origin, that has any ownership or interest in either the Insured or the Insured's ultimate owner or holding Company and their percentage holding.

_____

c) Length of current operation by present Parent / Owner: _____

2. PLEASE STATE THE APPLICANT'S TOTAL GROSS FEE INCOME / REVENUES / GROSS RECEIPTS:

a) For the past Financial Year: _____

b) Estimate for the current Financial Year: _____

3. PLEASE GIVE A FULL DESCRIPTION OF THE APPLICANT'S BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (this must be answered):

_____

_____

_____

_____

4. A) WHAT PERCENTAGE OF FUNDS ARE GENERATED FROM:

Government / public? _____%

Private funding? _____%

Charitable donations? _____%

B) WHAT ARE THE APPROXIMATE PERCENTAGES OF PATIENTS FROM:

Government / public? _____%

Private funding? _____%

Charitable donations? _____%

C) WHAT, IF ANY, SUBSTANTIAL CHANGES IN THE APPLICANT'S ACTIVITIES OR MAJOR NEW DEVELOPMENTS ARE LIKELY TO OCCUR WITHIN THE NEXT 12 MONTHS?

Please give full detail

_____

_____

5. IS THE APPLICANT LICENSED AND REGISTERED IN ACCORDANCE WITH THE APPLICABLE REGULATORY BODY OR LAW TO PRACTISE THOSE PROCEDURES AT THE ADDRESS SPECIFIED ON PAGE ONE FOR WHICH INDEMNIFICATION IS REQUIRED?

☐ Yes ☐ No If No, please give full details:

_____

_____

6. IS THE APPLICANT 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:

_____

Has membership of / registration with such organization / body ever been suspended, withdrawn, amended or declined or had conditions attached? ☐ Yes ☐ No If Yes, please give full details:

_____

_____

7. DOES THE ESTABLISHMENT HAVE:

a) C.A.T. / M.R.I. Scanners or similar? ☐ Yes ☐ No If Yes, please provide details of any maintenance agreement:

_____

b) Medical teaching facilities? ☐ Yes ☐ No

c) Nursing teaching facilities? ☐ Yes ☐ No

d) Pathology Laboratory ☐ Yes ☐ No

e) Any ambulances owned? ☐ Yes ☐ No _____

f) Any air ambulances owned/operated? ☐ Yes ☐ No _____

8. PLEASE STATE THE TOTAL NUMBER OF BEDS AND AVERAGE DAILY OCCUPANCY:

	NUMBER	A.D.O
Beds		
Bassinets / Cribs / Cots		
I.C.U. / I.T.U.		

9. PLEASE STATE:

a) The total number of admitted in-patients last year: _____

b) What, if any, percentage of patients in the last year came from USA: _____%

c) What, if any, percentage of the patients / clients in the last year who may be residents in Canada, come from USA: _____%

10. PLEASE IDENTIFY THE APPROXIMATE PERCENTAGES OF PROCEDURES PERFORMED ON **ADMITTED** IN-PATIENTS WITHIN THE FOLLOWING CATEGORIES:

	APPROXIMATE PERCENT		APPROXIMATE PERCENT
Accident & Emergency* (Addendum 5)	%	Maternity/Obstetrics* (Addenda 3 & 5)	%
Assisted Conception* (Addendum 1)	%	Organ Transplant	%
Clinical Trials* (Addendum 2)	%	Pediatric	%
Communicable Diseases	%	Psychiatric	%
Drug/Alcohol Dependency	%	Tropical Diseases	%
Dental	%	Other Minor Surgery	%
Elective Cosmetic	%	Intermediate Surgery	%
Elective T.O.P.* (Addendum 4)	%	Major Surgery	%
Gender Reassignment	%	Keyhole Surgery	%
Geriatric	%	TOTAL 100%	0 %

Where indicated with an * please complete sections of the Addenda as indicated.

Please state the number of Operating Theatres: _____

11. PLEASE GIVE DETAILS OF:

Any procedure(s) performed at any Out Patient Clinic(s) which is / are NOT included in the above information or set out in a separate proposal form. Please specify the approximate number of patients treated and percentage of Gross Fee Income / Revenues / Gross Receipts derived during the past Financial year.

	PATIENTS PER ANNUM	% OF TOTAL INCOME		PATIENTS PER ANNUM	% OF TOTAL INCOME
Antenatal Clinic		%	Laser Eye Surgery		%
Assisted Conception		%	Nutrition / Diet / Slimming		%
Dental		%	S.T.D.		%
Elective Cosmetic		%	Sports Injury		%
Elective T.O.P.		%	Well Man		%
HIV/HEP (inc Counselling)		%	Well Woman		%
Other Medical: _____ _____		%	TOTAL 100%	0	0 %

PLEASE NOTE THAT THIS POLICY IS DESIGNED TO COVER CLAIMS MADE AGAINST THE APPLICANT. If cover is also required for claims made against registered medical practitioners for work performed at the insured, please supply a list of all doctors for whom coverage is required stating the name, D.O.B., qualifications and practice of each doctor. In addition to this please confirm whether or not the doctors are employed by the insured or self-employed.

12. PLEASE STATE THE TOTAL NUMBER OF PERSONS INVOLVED IN THE FOLLOWING CAPACITIES:

	EMPLOYED BY THE APPLICANT	SELF-EMPLOYED		EMPLOYED BY THE APPLICANT	SELF-EMPLOYED
Non procedural Physicians:			Nurses - Day		
Psychiatrists			Nurses - Night		
Other _____			Pharmacists		
Surgeons:			Paramedics		
Cosmetic			Resident Medical Officers		
Orthopedic			Complementary Professionals		
Other _____			Supplementary Professionals		
Anesthetists			Auxiliaries - Qualified		
Obstetricians			Auxiliaries - Non-Qualified		
Gynecologists			Counsellors		
Lab/Path Technicians			Directors/Partners/Principals		
Dentists			Clerical/Administration		
Midwives			Other (please specify):		
Nurse Anesthetists			_____		

13. DOES THE APPLICANT ENSURE AND RECORD THAT AT ALL TIMES ALL REGISTERED MEDICAL AND DENTAL PRACTITIONERS ARE MEMBERS OF A MEDICAL/ DENTAL DEFENCE ORGANIZATION, RECOGNIZED BY THE APPLICANT'S NATIONAL MEDICAL/ DENTAL ASSOCIATION, OR ARE OTHERWISE FULLY INSURED FOR THEIR OWN MALPRACTICE?

☐ Yes ☐ No If No, refer to the NOTE at the top of this page.

14. ARE ANY COUNSELLING SERVICES MADE AVAILABLE TO PATIENTS?

☐ Yes ☐ No If Yes:

a) Please indicate in which of the following categories:

CATEGORY	NUMBER OF COUNSELLORS	EMPLOYED	SELF-EMPLOYED	NUMBER OF PATIENTS
Assisted Conception				
Drug/Alcohol Dependency				
Elective Cosmetic				
Elective T.O.P.				
Gender Reassignment				
HIV / HEP / STD				
Sterilization				
Other (specify) _____				

b) Do all Counsellors hold appropriate qualifications? ☐ Yes ☐ No Please provide details:

_____

_____

15. A)DOES THE APPLICANT OR ANY MEMBER OF STAFF INVOLVED IN THE TREATMENT OR CARE OF PATIENTS SUFFER FROM ANY DISABILITY, TRANSMITTABLE DISEASES 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 provide details:

_____

_____

16. DOES THE APPLICANT HAVE A BLOOD BANK? ☐Yes ☐No

a) Please state average number of units of blood or blood products used by the applicant's Establishment in any one calendar month: _____

b) Is 100% of the above bought or obtained from the applicant's National Blood Transfusion Service or National Red Cross? ☐Yes ☐No If No, please give full details:

_____

_____

Are all blood or blood products tested for transmittable diseases in accordance with the National Blood Transfusion Service, National Red Cross Society or an equivalent body prior to use? ☐Yes ☐No

If Yes, please list all tests carried out:

_____

_____

If No, please give full details:

_____

_____

Please provide full details of storage facilities and procedures:

_____

_____

17. PLEASE GIVE FULL DETAILS OF WHAT PATIENT RECORDS ARE KEPT, WHERE & 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.

18. A) DOES THE APPLICANT 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:

_____

_____

If Yes, does the applicant ensure that effective cross-infection control methods are employed? ☐Yes ☐No

_____

B) DOES THE APPLICANT HAVE A PROTOCOL FOR NEEDLESTICK INJURIES? ☐Yes ☐No

If No, please give full details:

_____

_____

If the applicant requires public liability insurance for their properties please complete the following section:

PREMISES COVERAGE

19. PLEASE GIVE FULL DETAILS ABOUT THE PREMISES, INCLUDING NUMBER OF BUILDINGS AND THEIR AGE AND ANY ANTICIPATED MATERIAL DEVELOPMENTS:

a) Number of buildings: _____

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

_____

_____

_____

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

d) i) What premises functions or facilities does the applicant sub contract?

_____

ii) What systems are in place to ensure that those sub contractors carry adequate insurance and name the applicant's organization as an additional Insured to their insurances?

_____

_____

e) What precautions / instructions are taken / issued in the use of cleaning solvents or other substances likely to be harmful to health and does the applicant warn users and third parties of these hazards?

☐ Yes ☐ No If Yes, please give details:

_____

_____

☐ Yes ☐ No If No, please provide full details:

_____

_____

20. A) DO THE PREMISES COMPLY WITH CURRENT FIRE PRECAUTION / PREVENTION REQUIREMENTS?

☐ Yes ☐ No If No, please give details:

_____

_____

B) ARE STAFF INSTRUCTED AND KEPT REGULARLY APPRAISED IN FIRE AND EMERGENCY PROCEDURES? ☐ Yes ☐ No

C) DO THE PREMISES HAVE AN EMERGENCY ELECTRICAL SYSTEM? ☐ Yes ☐ No

21. A) DOES THE APPLICANT PROVIDE FACILITIES FOR SAFE COLLECTION, STORAGE AND DISPOSAL IN ACCORDANCE WITH CURRENT GUIDELINES / LEGISLATION OF:

'Sharps' ☐Yes ☐No

Dressings, clinical / surgical waste etc. ☐Yes ☐No

B) DOES THE APPLICANT ENSURE THAT THE FOLLOWING ARE SAFELY DISPOSED OF IN ACCORDANCE WITH CURRENT GUIDELINES / LEGISLATION:

All blood / blood products? ☐Yes ☐No

All other waste? ☐Yes ☐No

PREVIOUS INSURANCE HISTORY

Please refer to your broker/insurance agent if you are in any doubt as to what is being asked of you in this section.

22. HAS THE APPLICANT PREVIOUSLY INSURED FOR PROFESSIONAL LIABILITY?

☐Yes ☐No If Yes, please provide:

Name of insurer: _____

Date the Policy expires: _____ Limit of Liability: _____

Deductible: _____ Retroactive Date: _____

Basis of cover (claims made or occurrence based):_____

If No, please provide details:

_____

_____

23. HAS THE APPLICANT PREVIOUSLY INSURED FOR COMMERCIAL GENERAL LIABILITY?

☐Yes ☐No If Yes, please provide:

Name of insurer: _____

Date the Policy expires: _____ Limit of Liability: _____

Deductible: _____ Retroactive Date: _____

Basis of cover (claims made or occurrence based):_____

If No, please provide details:

_____

_____

24. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS? ☐Yes ☐No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER? ☐Yes ☐No

If the answer to either 24 A) or 24 B) is Yes, complete the enclosed CLAIMS HISTORY FORM.

Note: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 24 A) AND/OR 24 B) OR ANY ERROR, ACT, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

25. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENSE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

☐Yes ☐No If Yes, please provide details:

_____

_____

26. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE, FOR THE APPLICANT, ANY PRESENT PARTNER OR OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS?

☐Yes ☐No If Yes, please provide details:

_____

_____

27. WHEN IS YOUR FISCAL YEAR END? _____

28. PLEASE INDICATE WHICH LIMIT(S) OF LIABILITY THE APPLICANT REQUIRES QUOTATIONS FOR:

☐ 1 million ☐ 2 million ☐ 3 million ☐ 4 million ☐ 5 million

☐ Other (please specify): _____

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this declaration does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 24 a) or 24 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: _____ Dated: _____

Print Name and Title: _____

BROKER NAME: _____

ADDRESS: _____

_____

_____

PHONE NO: _____

FAX NO: _____

EMAIL ADDRESS: _____

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ADDENDUM 1 – ASSISTED CONCEPTION

1. IF AN ASSISTED CONCEPTION UNIT IS MAINTAINED, PLEASE GIVE A FULL BREAKDOWN OF THE NUMBER OF CYCLES 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) _____

---

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. DOES THE APPLICANT RECEIVE A FULL INDEMNITY FROM THEIR 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 REVENUES: _____

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 THE APPLICANT WILL BE INVOLVED DURING THE NEXT 12 MONTHS DETAILING THE NUMBER OF VOLUNTEERS IN EACH TRIAL:

   _____

   _____

9. DOES THE APPLICANT CONDUCT ANY FORMAL RESEARCH, TESTING OR EXPERIMENTAL ACTIVITIES IN THE FOLLOWING CATEGORIES: TRANSPLANT, HUMAN EMBRYO RESEARCH, SURGERY, ARTIFICIAL ORGAN, OBSTETRICS, GENETIC ENGINEERING? ☐Yes ☐No

   If Yes, please attach full details.

   _____

   _____

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

ADDENDUM 3 – MATERNITY / OBSTETRICS

1. PLEASE STATE THE NUMBER OF DELIVERIES PER ANNUM: _____

   Including: Multiple Births _____

   Healthy Neonatals _____

   Stillborn Infants _____

   Infants delivered at less than 32 weeks gestation: _____

   Infants delivered at less than 1501 grammes _____

   Infants with an Apgar rate of less than 6 at five minutes: _____

   Number of infants admitted to the NICU/SCBU _____

   a) from the applicant's own Obstetrical Department: _____

   b) transferred from entities outside the control of the applicant: _____

2. IS AN OBSTETRICIAN AVAILABLE 'IN-HOUSE' 24 HOURS PER DAY? ☐Yes ☐No

3. IS A SECOND OBSTETRICIAN ON CALL 24 HOURS PER DAY WHO IS ABLE TO ATTEND WITHIN 30 MINUTES? ☐Yes ☐No

4. IS A PEDIATRICIAN AVAILABLE IN-HOUSE 24 HOURS PER DAY? ☐Yes ☐No

5. IS AN ANESTHETIST AVAILABLE SOLELY TO THE OBSTETRICAL DEPARTMENT 24 HOURS A DAY? ☐Yes ☐No

6. IS A SECOND ANESTHETIST ON CALL 24 HOURS PER DAY WHO IS ABLE TO ATTEND WITHIN 30 MINUTES? ☐Yes ☐No

7. CAN EMERGENCY CAESAREAN SECTIONS BE PERFORMED WITHIN 30 MINUTES 24 HOURS PER DAY? ☐Yes ☐No

8. CAN MIDWIVES ATTEND BIRTHS WITHOUT AN ATTENDING DOCTOR? ☐Yes ☐No

9. CAN OUTSIDE DOCTORS ATTEND THEIR OWN PATIENTS? ☐Yes ☐No

10. PLEASE GIVE BRIEF DETAILS OF THE APPLICANT'S POLICY IN RESPECT OF MOTHER AND FOETAL MONITORING:

    _____

    _____

11. DOES THE APPLICANT OFFER COUNSELLING SERVICE FOR PARENTS FOLLOWING MISCARRIAGE, OR PERINATAL DEATH, OR THE BIRTH OF HANDICAPPED CHILDREN? ☐Yes ☐No

ADDENDUM 4 – ELECTIVE T.O.P.

1. IF ELECTIVE T.O.P.'S ARE UNDERTAKEN, PLEASE PROVIDE A FULL BREAKDOWN OF THE NUMBERS OF PROCEDURES BY GESTATION PERIOD AT TIME OF TERMINATION:

   Up to 12 weeks _____

   12 to 16 weeks _____

   16 to 20 weeks _____

   20 to 24 weeks _____

   Over 24 weeks _____

ADDENDUM 5 – EMERGENCY CARE

1. PLEASE INDICATE WHICH OF THE FOLLOWING BEST DESCRIBES THE EXTENT OF EMERGENCY CARE PROVIDED BY THE APPLICANT:

   ☐ Comprehensive emergency care is available 24 hours a day and includes anaesthetic, medical and surgical services by resident medical staff, with other speciality consultation available within approximately 30 minutes.

   ☐ A Doctor is always present in the emergency care area with speciality consultation available within approximately 30 minutes.

   ☐ Emergency care is provided within approximately 30 minutes through a medical staff call roster.

   If none of the above, please provide full details.

CLAIMS HISTORY FORM

Applicant Name: ______________________________ Date: ____________________

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$