GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

A subsidiary of ONE80 INTERMEDIAIRES

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APPLICATION – **MEDICAL MALPRACTICE INSURANCE**

REGISTERED MEDICAL PRACTITIONERS

Full Name of the Applicant: _____

Trading Name (if different from above): _____

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. A) AT WHICH MEDICAL / DENTAL SCHOOL DID THE APPLICANT QUALIFY?

_____

B) IN WHAT YEAR? _____

C) DEGREE OBTAINED? _____

Please give details of any additional or post graduate qualifications:

_____

2. A) PLEASE STATE:

a) The name of the applicant's registration or licensing body: _____

b) The applicant's registration number: _____

c) The applicant's registration date: _____

d) The applicant's registration type: _____

e) Date of first registration: _____

f) Are there now or have there ever been any conditions attached to the applicant's registration? ☐ Yes ☐ No

g) Has there ever been any interruption in the applicant's registration? ☐ Yes ☐ No

If Yes to 2. f) or g), please provide full details:

_____

3. A) IN WHAT BRANCH OR BRANCHES OF MEDICINE IS THE APPLICANT QUALIFIED AND LICENSED TO PRACTISE?

☐ Anesthesiologist
☐ Cardiology
☐ Community Medicine
☐ Dermatology
☐ Dentistry*
☐ Endocrinology
☐ General Practice
☐ Genetics
☐ Hematology
☐ Immunology
☐ Industrial Health
☐ Neurology
☐ Nuclear Medicine
☐ Nutrition
☐ Obstetrics/Gynecology*
☐ Ophthalmology*
☐ Orthopedics
☐ Orthodontics
☐ Otorhinolaryngology
☐ Pediatrics
☐ Pathology
☐ Pharmacology
☐ Physiology
☐ Psychiatry
☐ Radiotherapeutics
☐ Rehabilitation
☐ Surgery*
☐ Tropical Medicine
☐ Venereology
☐ Other (please specify):_____

Where marked with an * please complete the relevant sections of the Addenda.

B) IF THE APPLICANT IS EITHER A G.P. OR AN OBSTETRICIAN/GYNECOLOGIST PLEASE STATE THE NUMBER OF:

i) Emergency non hospital births they attended in the last 12 months: _____

ii) Routine home births they attended in the last 12 months: _____

C) IF THE APPLICANT IS A SURGEON PLEASE GIVE FULL DETAILS OF THE TYPE OF SURGERY PERFORMED, E.G. CARDIAC / GENDER REASSIGNMENT /ELECTIVE COSMETIC / ELECTIVE T.O.P. / ORGAN TRANSPLANT / KEYHOLE / LASER EYE OR OTHER MAJOR OR INTERMEDIATE OR MINOR SURGERY:

_____

_____

4. A) IS THE APPLICANT INVOLVED IN CLINICAL TRIALS FOR WHICH THEY REQUIRE COVER?

☐ Yes ☐ No

If Yes, is the applicant under contract with any third party to conduct trials on their behalf? ☐ Yes ☐ No

If Yes, to whom are they under contract? _____

B) DOES THE APPLICANT RECEIVE A FULL INDEMNITY FROM THEIR PRINCIPALS? ☐ Yes ☐ No

C) DO ALL VOLUNTEERS SIGN AN INFORMED CONSENT FORM? ☐ Yes ☐ No

D) IF DOUBLE BLIND STUDIES ARE UNDERTAKEN ARE VOLUNTEERS MADE FULLY AWARE OF THIS? ☐ Yes ☐ No

E) DO ANY TRIALS INVOLVE ANY FEMALE VOLUNTEERS OF CHILD-BEARING AGE? ☐ Yes ☐ No

If Yes, please attach full details.

F) PLEASE STATE THE NUMBER OF TRIALS PERFORMED DURING THE LAST 12 MONTHS, DETAILING THE NUMBER OF VOLUNTEERS IN EACH TRIAL:

_____

_____

_____

G) 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:

_____

_____

_____

H) DOES THE APPLICANT CONDUCT ANY FORMAL RESEARCH, TESTING OR EXPERIMENTAL ACTIVITIES IN THE FOLLOWING CATEGORIES?

Transplant Surgery	Genetic Engineering Human Embryo Research	Artificial Organ Obstetrics

☐ Yes ☐ No If Yes, please attach full details.

Please provide copies of the informed consent form and any indemnities referred to in questions B) and C) above.

5. 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.

6. WHAT IS THE APPLICANT'S TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS? (If new business please state estimated income for the forthcoming 12 months) $_____

7. DOES THE APPLICANT OWN (WHOLLY OR IN PART), OPERATE OR ADMINISTER ANY HOSPITAL, NURSING HOME OR ANY OTHER MEDICAL ESTABLISHMENT? ☐ Yes ☐ No

If the answer is Yes, an additional proposal form will have to be completed before quotations can be given.

8. PLEASE STATE THE APPROXIMATE PERCENTAGE BREAKDOWN OF WORK BETWEEN THE FOLLOWING CATEGORIES AND STATE WHETHER THE APPLICANT IS EMPLOYED OR SELF-EMPLOYED.

CATEGORY	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	0 %	0 %

If the applicant is an employee, please state the name of the employing authority or the name of the private hospital or company for which they work.

_____

9. PLEASE STATE THE NUMBER OF STAFF AND GIVE DETAILS OF THE CAPACITY IN WHICH THEY PRACTISE:

_____

_____

10. 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:

_____

_____

_____

11. 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:

_____

_____

12. IF THE APPLICANT IS AN EMPLOYEE, IS IT A CONDITION OF THEIR EMPLOYMENT THAT THEY MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE OR THAT THEY BE A MEMBER OF ANY DEFENCE ORGANIZATION?

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

_____

_____

13. 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:

_____

_____

14. 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 14 A) or 14 B) is Yes, complete the enclosed CLAIMS HISTORY FORM.

Note: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 14 A) AND/OR 14 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

15. 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:

_____

_____

_____

16. 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:

_____

_____

_____

17. INSURANCE REQUIRED:

LIMITS:

- ☐ $250,000/$500,000
- ☐ $500,000/$1,000,000
- ☐ $1,000,000/$1,000,000
- ☐ $1,000,000/$2,000,000
- ☐ $2,000,000/$2,000,000
- ☐ $3,000,000/$3,000,000
- ☐ $4,000,000/$4,000,000
- ☐ $5,000,000/$5,000,000
- ☐ Other _____

DEDUCTIBLE

- ☐ $2,500(Min.)
- ☐ $5,000
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000
- ☐ Other _____

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 14 a) or 14 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 – DENTISTRY

1. ARE GENERAL ANAESTHETICS EVER ADMINISTERED?:

   ☐Yes ☐No If No, please proceed to question 10.

2. DOES THE APPLICANT PERSONALLY ADMINISTER GENERAL ANAESTHETICS?

   ☐Yes ☐No If No, please proceed to question 5.

3. DOES THE APPLICANT HAVE APPROPRIATE POST-GRADUATE TRAINING AND RELEVANT EXPERIENCE IN THE USE OF ANAESTHETIC DRUGS FOR DENTAL PURPOSES?

   ☐Yes ☐No If Yes, please provide details:

   _____

   _____

4. DOES A DENTIST OTHER THAN THE APPLICANT TREAT THE PATIENT? ☐Yes ☐No

5. IF THE ANSWER TO QUESTION 2 IS 'NO', IS THE ANAESTHETIC ADMINISTERED BY A DENTAL OR MEDICAL PRACTITIONER WITH APPROPRIATE POST-GRADUATE TRAINING AND RELEVANT EXPERIENCE IN THE USE OF ANAESTHETIC DRUGS FOR DENTAL PURPOSES? ☐Yes ☐No

6. DOES THE PERSON ADMINISTERING THE ANAESTHETIC (THE 'ANESTHETIST') ALWAYS REMAIN WITH THE PATIENT THROUGHOUT THE ANAESTHETIC PROCEDURE AND UNTIL THE PATIENT'S PROTECTIVE REFLEXES HAVE RETURNED AND THE PATIENT HAS RECOVERED CONTROL OF HIS / HER OWN AIRWAY? ☐Yes ☐No

7. HOW MANY ASSISTANTS ARE PRESENT THROUGHOUT THE PROCEDURE? _____

8. DOES THE 'ANESTHETIST' ALWAYS HAVE AN ASSISTANT IN SUPPORT THROUGHOUT THE PROCEDURE AND RECOVERY? ☐Yes ☐No

   If Yes, is the assistant specifically trained and experienced to assist in monitoring the patient's condition and in any emergency? ☐Yes ☐No

9. IS THE PERSON PROVIDING THE DENTAL TREATMENT ALWAYS ASSISTED BY A DENTAL SURGERY ASSISTANT / DENTAL NURSE? ☐Yes ☐No

10. IS SEDATION EVER ADMINISTERED? ☐Yes ☐ No If No, please proceed to question 12.

If Yes: i) Is this personally administered by the applicant? ☐Yes ☐ No
If No, please indicate the type of practitioner who administers the sedation (eg. Dentist or Anesthetist):

_____

ii) What type of sedation is administered? ☐ Intravenous ☐ Inhalational ☐ RA

iii) If you have indicated intravenous sedation, does the practitioner administering the sedation have post-graduate training in this procedure? ☐Yes ☐ No

11. IS A DENTAL SURGERY ASSISTANT / DENTAL NURSE PRESENT THROUGHOUT THE PROCEDURE? ☐Yes ☐ No

If Yes, does he / she have training and experience in assisting in procedures of sedation, including monitoring the clinical condition of the patient and assisting in an emergency? ☐Yes ☐ No

12. IS THE OPERATING ROOM EQUIPPED WITH CONTINUOUSLY-ACTING MONITORING DEVICES AND A DEFIBRILLATOR? ☐Yes ☐ No

13. IS THERE BASIC LIFE SUPPORT EQUIPMENT SETUP READY FOR USE IN THE OPERATING ROOM? ☐Yes ☐ No

14. ARE PATIENTS EVER LEFT UNATTENDED WHILST UNDER GENERAL ANAESTHESIA OR SEDATION OR IN RECOVERY? ☐Yes ☐ No

15. IS A FULL MEDICAL HISTORY OF THE PATIENT ALWAYS TAKEN PRIOR TO ADMINISTRATION OF GENERAL ANAESTHESIA OR SEDATION? ☐Yes ☐ No

16. ARE PATIENTS ALWAYS GIVEN WRITTEN PRE- AND POST-TREATMENT INSTRUCTIONS IN ADVANCE OF THE PROCEDURE? ☐Yes ☐ No

ADDENDUM 2 – OBSTETRICS / GYNECOLOGY / SURGEONS

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 _____

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

ADDENDUM 3 – OPHTHALMOLOGY

1. DO YOU PERFORM LASER EYE SURGERY? ☐ Yes ☐ No If Yes, please provide full details:

   _____

   _____

   _____

Signature of Applicant: _____ Dated: _____

Print Name and Title: _____

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	$