Medical Establishment Medical Professional Liability

1.a Full name of the Insured

1.b Trading Name (if different to 1.a)

1.c How long has the establishment traded under this name?

2 Have you ever engaged in a similar activity under a different name?

If YES please give full details YES ☐ NO ☐

3.a Trading Address

Post Code

3.b Telephone Number
Facsimile Number
Email Address

3.c Registered Office (if different from above)

Post Code

3.d Telephone Number
Facsimile Number
Email Address

If cover is required for more than one practice address, please complete a separate proposal form for each.

4.a Please name the ultimate Owner or Holding Company

4.b Please identify any private entity or corporation who are of either USA or Canadian origin, who have any interest or ownership in either the Insured or the Insured's ultimate owner or Holding Company and their percentage holding.

4.c Length of current operation by Present Owner

5 Please state your total Gross Fee Income / Turnover / Gross Receipts:

i) for the past Financial Year £
ii) for the current Financial Year (estimate) £

6 Please give a **FULL** description of your business activities for which cover is required

7.a What percentage of funds are generated from:

i)	Government / Public	%
ii)	Private funding	%
iii)	Charitable donations	%

7.b What are the approximate percentages of patients from:

i)	Government / Public	%
ii)	Private funding	%
iii)	Charitable donations	%

7.c Please give full details of what, if any, substantial changes in your activities or major new developments are likely to occur within the next twelve months?

8.a Are you licensed and registered in accordance with the applicable regulatory body or law to practise those procedures at the address specified in Question 3 for which you require indemnification?

YES ☐ NO ☐

If NO please give full details

8.b Are you a member of any Association or Professional Body, or registered with any self-regulating Organisation?

YES ☐ NO ☐

If YES please give full details including registration numbers

8.c Has membership or registration with any such body ever been suspended, withdrawn, amended, declined or had conditions attached?

YES ☐ NO ☐

If YES please give full details

9 Does the Establishment have any of the following:

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 Laboratories? YES ☐ NO ☐

e) Any self owned ambulances YES ☐ NO ☐ How Many

f) Any self owned / operated air ambulances YES ☐ NO ☐ How Many

10.a 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.		%

10.b Please state the total number of admitted in-patients:

Last Year	
Please state what percentage of patients were from the U.S.A or Canada	%
Please state what percentage of patients, resident in Britain, were from the U.S.A or Canada	%

11.a Please identify the approximate percentages of procedures performed on ADMITTED in-patients within the following categories:

Accident & Emergency*(*Addendum4) 4*)		Maternity / Obstetrics* (*Addendum.3&4)*	
Assisted Conception* (*Addendum 1*)		Organ Transplant	
Clinical Trials* (*Addendum 2*)		Paediatric	
Communicable Disease		Psychiatric	
Drug / Alcohol Dependency		Tropical Diseases	
Dental		Other Minor Surgery	
Elective Cosmetic		Intermediate Surgery	
Elective T.O.P		Major Surgery	
Gender Reassignment		Keyhole Surgery	
Geriatric		TOTAL 100%	

Where indicated with an * please complete the relevant addendum as indicated.

11.b Please state the number of Operating Theatres

12 Please give details of any procedures(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 / Turnover / Gross Receipts derived during the past Financial year.

	Patients Per Annum	% Of Total Income
Antenatal Clinic		%
Assisted Conception		%
Dental		%
Elective Cosmetic		%
Elective T.O.P		%
HIV. / HEP. (including Counselling)		%
Laser Eye Surgery		%
Nutrition / Diet / Slimming		%
STD		%
Sports Injury		%
Well Man		%
Well Woman		%
Other Medical*		%
TOTAL		%

***** Please give full details:

13 **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 PRACTITIONERS FOR WORK PERFORMED AT THE INSURED, PLEASE SUPPLY A LIST OF ALL DOCTORS FOR WHOM COVERAGE IS REQUIRED, AND ENCLOSE A FULL CV THAT MUST INCLUDE DETAILS OF NAME, D.O.B., QUALIFICATIONS AND PRACTICE OF EACH DOCTOR.
PLEASE ALSO CONFIRM WHETHER OR NOT THE DOCTORS ARE EMPLOYED BY THE INSURED OR SELF-EMPLOYED.

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

	Employed by Establishment	**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		
Residential Medical officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries – Day		
Auxiliaries – Night		
Directors / Partners / Principals		
Clerical / Administration		

Other – please specify

14 Do you ensure and record that at all times all Registered Medical and Dental Practitioners are members of a Medical / Dental Defence Organisation, recognised 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 AT QUESTION 13

15.a Are any counselling services made available to patients? YES ☐ NO ☐

15.b If YES please indicate in which of the following categories:

	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				
Sterilisation				

Other – please specify:

15.c Do all Counsellors hold appropriate qualifications? YES ☐ NO ☐

Please provide details below and attach full CV's

16 Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e. Hepatitis, HIV 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 to protect patients:

17.a Do you have a blood bank? YES ☐ NO ☐

17.b Please state the average number of units of blood or blood products used by your Establishment in any one calendar month:

17.c Is 100% of the above bought or obtained from your National Blood Transfusion Service or National Red Cross?

YES ☐ NO ☐

If NO please give full details:

17.d 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:

18 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 ten years, and in the case of minors, ten years from majority.

19.a Do you provide facilities for the sterilisation of instruments in accordance with current guidelines?

YES ☐ NO ☐

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

If YES do you ensure that effective cross-infection control methods are employed?

19.b Do you have a protocol for needlestick injuries? YES ☐ NO ☐

If NO please give full details:

PREMISES COVER

If you require Public Liability Insurance for your Properties please complete the following section:
Please give full details about the premises, including number of buildings and their age and any anticipated material developments.

20.a Number of buildings

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

20.c Are lifts, hoists, escalators and the like regularly serviced under contract? YES ☐ NO ☐

20.d i) What premises functions or facilities do you sub-contract?

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

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

YES ☐ NO ☐

If YES please give full details:

21.a Do the Premises comply with current fire precaution / prevention requirements? YES ☐ NO ☐

If NO give details:

21.b Are staff instructed and kept regularly appraised in fire and emergency procedures? YES ☐ NO ☐

21.c Do the Premises have an emergency electrical system? YES ☐ NO ☐

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

i) Sharps YES ☐ NO ☐

ii) Dressings, clinical / surgical waste etc.? YES ☐ NO ☐

22.b Do you ensure that the following are safely disposed of in accordance with current guidelines / legislation:

i) All blood / blood products? YES ☐ NO ☐

ii) 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.

FOR EACH POLICY:

23.a Who are the present Medical Professional and / or Public Liability Underwriters of the Insured?

23.b Has prior coverage been on a CLAIMS MADE BASIS? YES ☐ NO ☐

If YES please state:

i)	The retroactive date	
ii)	The present policy limits of insurance	£
iii)	The amount of self insured excess for each policy	£
Iv	The expiry date of the present policies	

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

i) Declined? YES ☐ NO ☐

ii) Cancelled? YES ☐ NO ☐

iii) Required special terms? YES ☐ NO ☐

If YES please give full details:

25.a List all claims made against the Insured during the last ten years for both Medical Professional and Public Liability. If **NONE** please state 'None':

Date of Incident	Date of	Amount Claime	Amount Paid	Amount Outstanding	Details including nature of the allegations and details of Claimant
		£	£	£	
		£	£	£	
		£	£	£	
		£	£	£	
		£	£	£	

25.b List all circumstances / complaints during the last ten years for both Medical Professional and Public Liability, which may give rise to a claim being made against the Insured.
If **NONE**, please state 'None':

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

26.a Have all of the above in question 16 been notified to your previous Underwriters: YES ☐ NO ☐

26.b Have all of the above been accepted by your previous Underwriters: YES ☐ NO ☐

27 Please indicate which limit(s) of indemnity you require quotation for:

£250,000 ☐ £500,00 ☐ £1,000,000 ☐ £2,000,000 ☐ Other £

This page forms your declaration to underwriters and can also be used to provide any additional information that you might want to provide pertinent to your Firm that may assist underwriters in their decision making process.

In all cases underwriters will require you to sign and date this form. If you present this proposal form to us electronically (by email) you will eventually be required to sign and date this form.

I/We declare that the statements and particulars in this proposal are true and that I/We have not mis-stated or suppressed any material facts. I/We agree that this proposal, together with any other information supplied by me/us shall form the basis of any Contract of Insurance effected thereon. I/We undertake to inform insurers of any material alteration to these facts occurring before completion of the Contract of Insurance. Returning this proposal does not bind the Proposer or Underwriter to complete this insurance but does authorise 'Sennet Professional Indemnity Limited' to seek terms on my/our behalf from Insurers including current Insurers if any.

Signed: Date:

(this must be signed by a Partner, Director or equivalent ranking employee)

All information provided to us and then to underwriters is governed by the DATA PROTECTION ACT 1998. Sennet Professional Indemnity Limited and Underwriters act strictly in accordance with the Act its principals and tenets and any subsequent amendments thereto.

WOULD YOU ALSO PROVIDE COPIES OF ANY BROCHURES YOU MAY HAVE, PATIENT CONSENT FORMS, PROTOCOL DETAILS WITH RESPECT TO DRUGS, FINANCIAL REPORTS AND ACCOUNTS AND ANY CONTRACTS THAT YOU MAY ENTER INTO.

Addendum 1 - Assisted Conception

i) 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)

Are counselling services made available to patients YES ☐ NO ☐

ii) Is all donor semen screened, cryopreserved and quarantined in line with current recommendations?

YES ☐ NO ☐

Addendum 2 - Clinical Trials

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 twelve 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 twelve 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	YES ☐ NO ☐	Human Embryo Research	YES ☐ NO ☐
Surgery	YES ☐ NO ☐	Artificial Organ	YES ☐ NO ☐
Obstetrics	YES ☐ NO ☐	Genetic Engineering	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 - 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	
i) from your own Obstetrical Department	
ii) transferred from entities outside the control of the Proposer	

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 thirty minutes?

YES ☐ NO ☐

4 Is a Paediatrician available 'in-house'24 hours per day?

YES ☐ NO ☐

5 Is an Anaesthetist available solely to the obstetrical department 24 hours a day?

YES ☐ NO ☐

6 Is a second Anaesthetist on call 24 hours per day who is able to attend within thirty minutes?

YES ☐ NO ☐

7 Can emergency Caesarean sections be performed within thirty 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 Proposer's policy in respect of mother and foetal monitoring:

10 Do you offer counselling service for parents following miscarriage, or perinatal death, or the birth of a handicapped child?

YES ☐ NO ☐

Addendum 4 - Emergency Care

1 Please indicate which of the following best describes the extent of emergency care provided by the Insured:

i) 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 thirty minutes ☐

ii) A Doctor is always present in the emergency care area with speciality consultation available within approximately thirty minutes ☐

iii) Emergency care is provided within approximately thirty minutes through a medical staff call roster. ☐

If none of the above, please provide full details.