MEDICAL ESTABLISHMENT MEDICAL PROFESSIONAL LIABILITY

BROKER / INSURANCE AGENT

Marketform®

Syndicate 2468 at Lloyd's and / or Acting as agent for Syndicate 2468 at Lloyd's

(Hospitals, Clinics, Nursing Homes etc...)

PLEASE READ THESE GUIDANCE NOTES BEFORE COMPLETING THE PROPOSAL FORM. WHERE FURTHER INFORMATION IS REQUIRED PLEASE REFER TO YOUR BROKER/INSURANCE AGENT.

PLEASE NOTE This Proposal Form is for a CLAIMS MADE policy. A CLAIMS MADE policy only responds to "claims" made against the Insured and notified to Underwriters during the period of insurance.

- This Proposal Form must be typed, or completed in ink and signed and dated by the Proposer. Please answer every question fully, and state "NIL" or "NONE" as applicable. Incomplete answers may not be accepted and can delay quotation.
- Where more than one location or establishment is to be included in the quotation, please complete a separate proposal form for each location or establishment.
- Please submit, with the Proposal, all relevant information including Financial Report and Accounts, Brochures, Consent Forms etc.
- Should there be insufficient room in the Proposal Form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.
- It is the duty of the Proposer to disclose all material facts to Insurers. Where this is omitted, the Underwriters may avoid their obligation under the Policy.

  For the purpose of the Proposal and for all purposes relating to any policy issued pursuant to this Proposal, a 'material fact' shall be deemed to be one that would be likely to influence an Underwriter's judgment and acceptance of your Proposal.
- Upon acceptance of the Underwriters' terms and conditions and payment of the premium, all information provided by the Proposer together with the guidance notes will be deemed to be incorporated in the contract between Underwriters and the Insured.

Copies of the Proposal Forms should be retained for your own records.

1. i) Full name of the Insured:

ii) Trading name if different from above:

iii) How long has the establishment been trading under the above name?

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

YES ☐ NO ☐

If 'YES' please see Question 6 and provide full details in the same numerical order on a separate sheet.

3. i) Trading address:

Postal Code: _____ Country: _____

Telephone Number: _____

Facsimile Number: _____

ii) Registered Office (if different from above):

Postal Code: _____ Country: _____

Telephone Number: _____

Facsimile Number: _____

NB: If cover is required for additional locations, a separate proposal form for each must be completed.

SIGNING OF THIS PROPOSAL FORM DOES NOT BIND THE PROPOSER OR UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE

Notice to Proposers resident in the EU

The parties completing this Contract are free to choose the law applicable to this Contract. However, unless it is specifically agreed to the contrary, the Contract shall be subject to the law of the Country stipulated in the applicable EC Insurances pre-contractually required in accordance with the Third EU Non-Life Directive.

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

i) for the past Financial Year

ii) estimate for the current Financial Year

6. PLEASE GIVE A FULL DESCRIPTION OF YOUR BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (this must be answered):

7. i) What percentage of funds are generated from:

a) Government / public? %

b) Private funding? %

c) Charitable donations? %

ii) What are the approximate percentages of patients from:

a) Government / public? %

b) Private funding? %

c) Charitable donations? %

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 practise those procedures at the address specified in Question 3 for which indemnification is required?

YES ☐ NO ☐

If 'NO' please give full details:

ii) Are you a member of any Association or Professional Body, or registered with any self-regulating Organisation?

YES ☐ NO ☐

If 'YES' please state which:

iii) Has membership or registration with such ever been suspended, withdrawn, amended, declined or had conditions attached?

YES ☐ NO ☐

If 'YES' please give full details:

9. Does the Establishment have:

i) C.A.T. / M.R.I. Scanners or similar? YES ☐ NO ☐

If 'YES', please provide details of any maintenance agreement:

ii) Medical teaching facilities? YES ☐ NO ☐

iii) Nursing teaching facilities? YES ☐ NO ☐

iv) Pathology Laboratori`Y˜ VuÉ ☐ NO ☐

v) Any ambulances owned?

vi) Any air ambulances owned / operated?

10. i) 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.		%

ii) Please state the total number of admitted in-patients:

Last year

Please state what, if any, percentage of your patients came from U.S.A. or Canada %

Please state what, if any, percentage of your clients who may be resident in Britain come from USA or Canada %

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

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

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

ii) Please state the number of Operating Theatres:

12. 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 / 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 (inc Counselling)		
Laser Eye Surgery		
Nutrition / Diet / Slimming		
S.T.D.		
Sports Injury		
Well Man		
Well Woman		
Other Medical*		
Total		

*(please give 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 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.

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 Practitioners		
Nurse Anaesthetists		
Nurses - Day		
Nurses - Night		
Pharmacists		
Paramedics		
Residential Medical Officers		
Complementary Professionals		
Supplementary Professionals:		
Auxiliaries - Qualified		
Auxiliaries - Non-Qualified		
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' refer to the NOTE in Question 13.

15. Are any counselling services made available to patients?

YES ☐ NO ☐

If 'YES':

i) 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):

ii) Do all Counsellors hold appropriate qualifications?

YES ☐ NO ☐

Please provide details:

16. 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:

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

ii) Please state average number of units of blood or blood products used by your Establishment in any one calendar month:

iii) 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:

iv) 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 10 years, and in the case of minors, 10 years from majority.

19. i) 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?

ii) Do you have a protocol for needlestick injuries?

YES ☐ NO ☐

If 'NO' please give full details:

If you require Public Liability Insurance for your Properties please complete the following section:

PREMISES COVERAGE

20. 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 organisation as an additional Insured to their insurances?

v) 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 details:

21. i) Do the Premises comply with current fire 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 ☐

22. 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 ANY DOUBT AS TO WHAT IS BEING ASKED OF YOU IN THIS SECTION.

FOR EACH POLICY:

23. 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?

24. Has any application for these types 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:

PREVIOUS CLAIMS HISTORY

25.i) List all claims made against the Insured during the last 10 years for both Medical Professional and Public Liability, including any made against the Insured even if cover was not previously purchased. **IF NONE, PLEASE STATE "NONE"**:

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

ii) List all circumstances/complaints during the last 10 years for both Medical Professional and Public Liability, which may give rise to a claim being made against the Insured even if cover was not previously purchased. **IF NONE, PLEASE STATE "NONE"**:

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

26. i) Have all of the above in question 25 been notified to your previous Underwriters? YES ☐ NO ☐

ii) Have all of the above been accepted by your previous Underwriters? YES ☐ NO ☐

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

☐ 1 million ☐ 2 million ☐ 3 million ☐ 4 million ☐ 5 million _____ Other

I/We declare and warrant that after enquiry all statements and particulars contained in this 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 this Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as practicable. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.

FOR AND ON BEHALF OF _____

Name of Insured

SIGNATURE _____ Dated _____

NAME OF PROPOSER _____ Position _____

(IN BLOCK CAPITALS)

ADDENDUM 1 - ASSISTED CONCEPTION

1. If an Assisted Conception unit is maintained, please give a full percentage 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 and indicate numbers)

   ☐

   Are counselling services made available to patients?

   YES ☐ NO ☐

2. 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 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	Human Embryo Research
Surgery	Artificial Organ
Obstetrics	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 30 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 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 Proposer's policy in respect of mother and foetal monitoring:

    ☐

11. Do you 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 to16 weeks ☐

   16 to 20 weeks ☐

   20 to 24 weeks ☐

   Over 24 weeks ☐

ADDENDUM 5 - EMERGENCY CARE

PLEASE TICK BOX

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 30 minutes. ☐

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

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

If none of the above, please provide full details.

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

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