

## Medical Malpractice Private Clinics & Hospitals Insurance Application Form (UK & Channel Islands)

**NOTE TO PERSON COMPLETING THIS FORM:** THIS APPLICATION FORM IS AN IMPORTANT DOCUMENT AND IS BEING RELIED ON BY THE INSURER TO DETERMINE WHETHER IT WILL PROVIDE COVERAGE. PLEASE ENSURE THAT ALL RESPONSES ARE ACCURATE AND CORRECT. THIS APPLICATION FORM WILL BECOME PART OF THE INSURANCE POLICY.

Please use additional pages where necessary to provide complete responses.

**"PROPOSER"** means the firm, practice, company or other entity including all partners (if set up as a partnership) proposing for this insurance, and any subsidiaries and previous firms, practices, companies or other entities (and partners if relevant) requiring coverage.

This application form must be completed in ink, signed and dated by the Principal, Managing Director, Senior Partner, Compliance Officer or Insurance/Risk Manager of the **PROPOSER** (or any Partner or Director who has been with the **PROPOSER** for at least 3 years). All questions must be answered and where appropriate "Not Applicable" or "N/A" specified. The completed application form along with all additional information provided will form part of the contract of insurance with the Insurer. All facts material to the proposed insurance must be disclosed fully and truthfully and to the best of the **PROPOSER**'s knowledge and belief whether or not they are the subject of a specific question herein. In addition to the information contained in the application form including all supporting documentation, if the **PROPOSER** is aware of any other information which it considers may alter, influence or prejudice the Insurer's appraisal of the risk being proposed, this information must be disclosed in conjunction with this application form.

It is agreed by the **PROPOSER** that any information provided to Insurers will be processed by Insurers in compliance with the provisions of the Data Protection Act 1998, which may necessitate providing such information to third parties. By signing this proposal form the **PROPOSER** is consenting to the use of information, including sensitive personal information. Where personal information relates to third parties, the **PROPOSER** confirms that it has been given the requisite consent to disclose such information to Insurers for processing.

### This is a "Claims made" Insurance Proposal .

This insurance is underwritten on a "claims made" basis, which means that if a claim is made against the **PROPOSER** then the **PROPOSER MUST** have a current policy in force. Any claims brought against the **PROPOSER** after the expiry of the policy period (or any specific extended reporting period) will **NOT** be covered.

1. (a) Please provide the full name of the **PROPOSER** (including all entities requiring coverage):-
  
- (b) Date established:-
  
- (c) Principal address:-
  
- (d) Other operating addresses:-
  
- (e) Website address:-  
(It is understood and agreed that material in the **PROPOSER**'s website is not deemed to form part of this application form apart from any information attached in hard copy to this form)

2. (a) Please provide a full description of the **PROPOSER**'s activities (including any activities undertaken in the last six years not currently undertaken and any new activities planned for the next twelve months):-

(b) Does the **PROPOSER** undertake any activities outside the UK:- **YES/NO**  
If **YES**, please provide full details:-

(c) Please advise the status of the **PROPOSER** as follows:-

Privately owned **YES/NO** If **YES**, please advise by whom:-  
Publicly owned **YES/NO**  
Charitable **YES/NO**  
Other (please specify) **YES/NO**

(d) Please advise the total number of medically qualified staff for each general category as detailed in the table below. The definition for each type is as follows (please use the most appropriate definition):-

- A. **EMPLOYED** – Any professional working under a contract of service solely for the **PROPOSER** (under a traditional PAYE arrangement);
- B. **FREE SERVICE / SELF-EMPLOYED** – Any independent professional working under a third party services agreement with the **PROPOSER**. Such Individual may undertake work separately and elsewhere for other medical entities;
- C. **CONTRACTED STAFF** – Any professional working for the **PROPOSER** within a pre-agreed timescale and under "project" terms of engagement. Such professionals are often contracted as a group. Examples include NHS Staff contracted to a private clinic.

MEDICAL PRACTITIONER	A. EMPLOYED With no Separate Insurance	A. EMPLOYED Insured With The MDU / MPS or Other Medical Body or Association	B. FREE SERVICE / SELF- EMPLOYED *	C. CONTRACTED STAFF
Surgeons & Consultants				
Doctors (GP's)				
Opticians & Optometrists				
Orthodontists & Dentists				
Radiologists / Scanners				
Chiropractors & Osteopaths				
Nurses				
Midwives				
Scientists & Laboratory Technicians				
Ambulance Staff & Paramedics				
Any Other Specialty (Please specify)				
<b>TOTAL</b>				

\* The Insurer stipulates that the **FREE SERVICE / SELF-EMPLOYED** individuals purchase separate medical malpractice insurance. If this is not the case, or in the unusual situation that any such individual requires cover under the **PROPOSER**'s insurance, this will have to be discussed and specifically agreed and endorsed by the Insurer on an individual basis.

3. (a) (i) When is the **PROPOSER's** Financial Year End?:-  
 (ii) Please provide the following information for each of the last three full financial years and the current incomplete financial year:-

<b>Financial Information: Should Be Detailed In British Pounds</b>	<b>Last Full Financial Year Ended:-</b>	<b>Previous Full Financial Year (1 year ago)</b>	<b>Previous Full Financial Year (2 years ago)</b>	<b>Estimate of Current Outstanding Financial Year</b>
<b>FINANCIAL</b>				
(i) Gross Revenue				
(ii) Wage Roll				
(iii) Net Profit (After Taxes)				
<b>OTHER INFORMATION</b>				
(iv) No of Beds				
(v) Average Bed Occupancy (%)				
(vi) No of Operating Theatres				
(vii) No of Ops Under General Anaesthetic				
(viii) No of Ops Under Local Anaesthetic				
<b>BIRTHS</b>				
(ix) No of Births (In Total)				
(x) No of Caesareans				
(xi) No of Still Born Births				
(xii) No of Baby Deaths After Birth				
(xiii) No of Births With Serious Defects				
(xiv) No With Apgar Rate < 6 after 5 Mins				
<b>PATIENT NUMBERS</b>				
(xv) No of In Patients Staying < 36 Hrs				
(xvi) No of In Patients Staying > 36 Hrs				
(xvii) No of Out Patients				
(xviii) No of Readmissions Within 36 Hrs				

- (b) Is the **PROPOSER** or any Principal, Partner or Director of the **PROPOSER's** business connected or associated (financially or otherwise) with any other Organisation with which the **PROPOSER** undertakes business? **YES/NO**  
 If **YES**, please provide details including what work is undertaken for and/or on behalf of such Organisation:-

4. Please provide the current number of MEDICAL PRACTITIONERS (detailed in question 2 (d)) and surgical procedures for each of the following treatment categories as follows:-

ACTIVITY	No of Medical Practitioners / Procedures				
	A. Employed	B. Free Service / Self Employed	C. Contracted	No of Surgical Procedures A + B	No of Surgical Procedures C
Anatomy / Histology					
Anaesthesia / Resuscitation					
Cardiology					
General Surgery					
Elective Cosmetic Surgery					
Reconstructive/Remedial Cosmetic					
Dental					
Dermatology					
Diabetes					
Elderly Care					
Fertility					
Gastroenterology					
Gynaecology (Non-Births)					
Obstetrics (Births)					
HIV / Hepatitis / STD's					
Immunology / Transfusions					
Laboratory Analysis					
Minor Day Surgery					
General Medicine					
Microbiology & Virology					
Dialysis					
Neonatal					
Neurosurgery					
Neurology					
Nutrition / Slimming					
Oncology / Cancer Care					
Eye Treatment					
Orthopaedic / Traumatology					
Ear Nose & Throat (ENT)					
Paediatrics / Children					
Podiatry					
Psychiatry					
Radiography / X Ray					
Rehabilitation / Physiotherapy					
Urology					
Other (Please Specify)					
<b>TOTAL</b>					

5. (a) In terms of the last full financial year, please can you detail the split in Gross Revenue attributable to each of the following general categories:-

Categories	PERCENTAGE
Births (Natural)	%
Births (Other)	%
Surgery Under General Anaesthetic (Ex Births)	%
Surgery Under Local Anaesthetic (Ex Births)	%
Fertility Procedures	%
Dialysis / Immunology / Transfusions	%
Non-Surgical Consultation / Screening / Scans	%
Other Categories (Please Specify)	%
<b>TOTAL</b>	<b>100%</b>

Please advise what percentage of the revenue earned in the last full financial year was from each of the following:-

Public Funding	PERCENTAGE
Private Insurance Schemes	%
Private Individuals	%
Charitable Donations	%
Other (Please Advise)	%
<b>TOTAL</b>	<b>%</b>

- (b) Is the **PROPOSER** currently insured for Medical Malpractice Insurance? **YES/NO**

If **YES** please provide details as follows (including answers to (i) and (ii) below):-

Insurer	Expiry Date	Limit	Excess	Retro-Active Date	Premium

- (i) Has the **PROPOSER** been continuously insured since the Retro-Active Date detailed above? **YES/NO**  
If **NO** please advise from which date such insurance has continuously been purchased:-
- (ii) Does this current policy have a Discovery Period or Extended Reporting Period in the event that the policy is not renewed? **YES/NO**  
If **YES**, how long is this Discovery Period or Extended Reporting Period?

- (c) Has the **PROPOSER** ever been refused similar insurance, or had any policy cancelled or voided at any time? **YES/NO**  
If **YES**, please provide full details:-

6. (a) Does the **PROPOSER** ensure that all **FREE SERVICE / SELF EMPLOYED** Medical Practitioners purchase separate medical malpractice insurance for a limit of indemnity of at least £1,000,000 (and continually renew such insurance) to ensure that all work undertaken for and on behalf of the **PROPOSER** is covered? **YES/NO**  
If **NO**, please advise under what circumstances this would not happen:-
- (b) Does the **PROPOSER** ensure that all Medical Practitioners working for and on behalf of the **PROPOSER** (whether **EMPLOYED, FREE SERVICE / SELF EMPLOYED** or **CONTRACTED**) are current subscribing members of a recognised Medical Institute or relevant Professional Body and hold the relevant required valid licences to practise in their respective areas of specialism? **YES/NO**  
If **NO**, please advise under what circumstances this would not happen:-
- (c) Does the **PROPOSER** screen all Medical Practitioners prior to and during employment with the **PROPOSER** for drug and/or alcohol abuse? **YES/NO**  
If **NO** please advise why this would not happen:-
- (d) Does the **PROPOSER** obtain satisfactory written references and confirmation of no historical medical malpractice related claims and/or circumstances for all Medical Practitioners prior to employing them or allowing them to use its premises? **YES/NO**  
If **NO** please advise why and when this would not happen:-
- (e) Does the **PROPOSER** confirm that none of the Medical Practitioners working on its premises are:-
- (i) Under disciplinary review by any Medical Institute or relevant Professional Body or involved in any civil or administrative proceeding regarding malpractice? **YES/NO**  
And:-
- (ii) Have been convicted for any felony or criminal offence, or are currently involved with a criminal proceeding of any kind? **YES/NO**  
If **NO** to (i) or (ii) above please provide full details:-
- (f) (i) Does the **PROPOSER** analyse and report on blood, urine and/or semen samples as part of its professional services? **YES/NO**
- (ii) If **YES**:- Is the analysis undertaken by a wholly independent third party laboratory? **YES/NO**  
If **YES**:- Please answer both of the following:-
- (iii) Has the **PROPOSER** entered into a written contract detailing the extent of services and the level of professional performance required by the laboratory? **YES/NO**
- (iv) Does the **PROPOSER** ensure that the laboratory has adequate Professional Indemnity insurance for the professional services it undertakes for and/or on behalf of the **PROPOSER**? **YES/NO**  
If **NO** to (iii) and/or (iv) above, please advise why not:-

- (g) Does the **PROPOSER** undertake that all new employees have adequate police checks and at least two bona fide referees prior to employment? **YES/NO**  
If **NO**, please provide reasons why not:-
- (h) Has the **PROPOSER** been satisfactorily audited within the last three years by a regulatory body? **YES/NO**  
If **YES**, was the audit successful, with no significant recommendations made? **YES/NO**  
If **NO**, please advise what the significant recommendations were and whether they have been satisfactorily instigated:-
- (i) Are all cheques and money transfers paid by the **PROPOSER** in excess of £5,000 subject to at least two authorised signatures? **YES/NO**  
If **NO**, please provide reasons why not including details of sole signature limit and authorised sole signatories:-
- (j) Is there a clearly defined control mechanism in place to ensure that all monies (including money transfers) paid to the **PROPOSER** are recorded, banked and reconciled independently within at most seven days of receipt? **YES/NO**  
If **NO**, please provide reasons why not:-
- (k) Does the **PROPOSER** maintain up to date case notes and medical records including accurate records of all procedures undertaken for each patient and observatory records of post-procedural recovery? **YES/NO**  
If **NO**, please advise under what circumstances this would not happen:-
- (l) Does the **PROPOSER** ensure that all treatment to patients under the age of consent is only undertaken with the consent of the relevant parent or legal guardian? **YES/NO**  
If **NO**, please provide full details when this does not happen:-
- (m) Does the **PROPOSER** ensure that in all reasonable instances an informed consent is obtained from the patient in writing before any surgical procedure is undertaken? **YES/NO**  
If **NO**, please advise when such consent would not be obtained.
- (n) Does the **PROPOSER** ensure that all relevant equipment used is sterile, and that sterilisation procedures are in place to ensure that this is the case in all instances? **YES/NO**  
If **NO**, please advise under what circumstances this would not happen:-
- (o) Does the **PROPOSER** have a service agreement with a specialist third party to ensure that all equipment is satisfactory serviced? **YES/NO**  
If **NO**, what steps does the **PROPOSER** make to ensure that all equipment performs its intended function to a satisfactory level?

**7. Medical Malpractice Insurance is underwritten on a 'claims made' basis and the Insurer will exclude any claim and/or circumstance which may give rise to a claim, which is known by the PROPOSER(s) prior to the inception date of the policy. Please provide answers to the following questions after making full enquiry of all Principals, Partners, Directors and employees.**

- (a) Have any professional negligence or medical malpractice claims ever been made against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER**, whether successful or otherwise? **YES/NO**
- (b) Have any claims for dishonesty ever been made against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER** whether successful or otherwise? **YES/NO**
- (c) Have any complaints or investigations ever been made or undertaken against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER**? **YES/NO**
- (d) Has the **PROPOSER** or any Director, Partner or employee of the **PROPOSER** ever had a document relating to the **PROPOSER**'s activities unintentionally destroyed, damaged, lost or mislaid? **YES/NO**
- (e) Has the **PROPOSER** ever suffered any losses due to dishonesty of any Director, Partner or employee, or any other person or organisation? **YES/NO**
- (f) Have any libel or slander claims ever been made against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER**, whether successful or otherwise? **YES/NO**
- (g) Have any infringement of copyright claims ever been made against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER**, whether successful or otherwise? **YES/NO**
- (h) Have any breach of confidentiality claims ever been made against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER**, whether successful or otherwise? **YES/NO**
- (i) Have any sexual harassment and/or abuse claims ever been made against the **PROPOSER** or against any Director, Partner or employee of the **PROPOSER**, whether successful or otherwise? **YES/NO**
- (k) After full enquiry is the **PROPOSER** or any Director, Partner or employee of the **PROPOSER** aware of any circumstances relating to the questions 7(a) to 7(i) above which may give rise to a potential claim or request for indemnity under the medical malpractice policy? **YES/NO**

If the answer to any of the above is **YES (for any of the last six years)**, please provide details below:-

Date of Loss	Date Notified	Claimant Name	Description of Claim	Excess	Payment Made By Insurers	Outstanding Reserve	Maximum Possible Loss	Status of Claim (e.g. Closed or Waiting for Legal Report)



**8. Declaration**

I/We declare that the above answers, statements, particulars and additional information are true to the very best of the knowledge and belief of the **PROPOSER**. After full enquiry, I/We also confirm that I/We have disclosed all information and material facts that may alter the Insurer's view of the risk, or affect their assessment of the exposures they are covering under the policy. I/We understand that all answers, statements, particulars and additional information supplied with this proposal form will become part of and form the basis of the policy.

**Signature**

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**Date**

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**Position**

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**For and/on behalf of the PROPOSER**

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**Name in capital letters (Printed)**

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Following the commencement of this contract of insurance, the **PROPOSER** must advise Insurers as soon as practicable, and as a matter of urgency, of any changes to the original information provided to Insurers when the Application Form was originally submitted to Insurers. Such information must include anything which it considers may alter, influence or prejudice the Insurer's appraisal of the risk being covered hereunder. Failure to disclose such new or amended information may prejudice the **PROPOSER**'S position in the event of notification of a Claim under this policy.