REGISTERED MEDICAL PRACTITIONERS

BROKER / INSURANCE AGENT

Marketform®

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

(Doctors, Dentists, 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.
- Please complete separate Proposal Forms for each Partner to be included in the quotation and attach a list of all Partners.
- Please submit any additional information you feel may be of assistance to Underwriters, such as Brochures 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 Underwriters. Where this is omitted, the Underwriters may avoid their obligation under the Policy.

  For the purposes 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. Full name of the Insured:

Date of birth:

2. Trading name (if different from the above):

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

YES ☐ NO ☐

If 'YES' please give full details:

4. i) Address:

Postal Code: ____ Country: ____

Telephone Number: ____

Facsimile Number: ____

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

Postal Code: ____ Country: ____

Telephone Number: ____

Facsimile Number: ____

IF COVER IS REQUIRED FOR MORE THAN ONE LOCATION, PLEASE ATTACH A LIST OF ALL ADDRESSES.

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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5. i) At which Medical / Dental School did you qualify?

ii) In what year?

iii) Degree obtained?

Please give details of any additional or post graduate qualifications:

6. Please state:

i) The name of your registration or licensing body:

ii) Your registration number:

iii) Your registration date:

iv) Your registration type:

v) Date of first registration:

vi) Are there now or have there ever been any conditions attached to your registration?

YES ☐ NO ☐

vii) Has there ever been any interruption in your registration?

YES ☐ NO ☐

If 'YES' to 6.vi) or vii) please provide full details.

7. i) In what branch or branches of medicine are you qualified and licensed to practise?

Anaesthesiology	☐	Ophthalmology*	☐
Cardiology	☐	Orthopaedics	☐
Community Medicine	☐	Orthodontics	☐
Dermatology	☐	Otorhinolaryngology	☐
Dentistry*	☐	Paediatrics	☐
Endocrinology	☐	Pathology	☐
General Practice	☐	Pharmacology	☐
Genetics	☐	Physiology	☐
Haematology	☐	Psychiatry	☐
Immunology	☐	Radiotherapeutics	☐
Industrial Health	☐	Rehabilitation	☐
Neurology	☐	Surgery*	☐
Nuclear Medicine	☐	Tropical Medicine	☐
Nutrition	☐	Venereology	☐
Obstetrics/Gynaecology*	☐		

Other (please specify):

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

ii) If you are either a G.P. or an Obstetrician/Gynaecologist please state the number of:

a) Emergency non hospital births you attended in the last 12 months:

b) Routine home births you attended in the last 12 months:

iii) If you are 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:

8. i) Are you involved in Clinical trials for which you require cover?

YES ☐ NO ☐

ii) If 'YES' are you under contract with any third party to conduct trials on their behalf?

YES ☐ NO ☐

iii) If 'YES' to whom are you under contract?

iv) Do you receive a full indemnity from your principals?

YES ☐ NO ☐

v) Do all volunteers sign an Informed Consent form?

YES ☐ NO ☐

vi) If Double Blind studies are undertaken are volunteers made fully aware of this?

YES ☐ NO ☐

vii) Do any trials involve any female volunteers of child-bearing age?

YES ☐ NO ☐

If 'YES' please attach full details.

viii) Please state the number of trials performed during the last 12 months detailing the number of volunteers in each trial:

ix) 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:

x) Do you conduct any formal research, testing or experimental activities in the following categories?

Transplant	Human Embryo Research
Surgery	Artificial Organ
Genetic Engineering	Obstetrics

YES ☐ NO ☐

If 'YES' please attach full details.

PLEASE PROVIDE COPIES OF YOUR INFORMED CONSENT FORM & ANY INDEMNITIES REFERRED TO IN QUESTIONS iv AND v ABOVE.

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9. 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.

10. WHAT IS YOUR TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS? (If new business please state estimated income for the forthcoming 12 months)

11. Do you 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

12. Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed.

	EMPLOYED	SELF - EMPLOYED
The Proposer's Private Practice		
Public Sector Hospitals / Homes		
Private Surgical Hospitals / Homes		
Private Non-Surgical Homes		
Patients' Homes		
Other (please specify)		
Total		

If you are an employee, please state the name of the employing authority or the name of the private hospital or company for which you work.

13. Please state the number of staff and give details of the capacity in which they practise:

14. i) Does the Proposer 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?

ii) Has the Proposer 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 give full details:

15. i) Are you a member of any professional organisation, or registered with any self regulating body?

YES ☐ NO ☐

If 'YES' please state which and period of membership / registration:

ii) Has membership of / registration with such organisation / body ever been suspended, withdrawn, amended or declined or had conditions attached?

YES ☐ NO ☐

16. If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance or that you be a member of any Defence Organisation?

YES ☐ NO ☐

If 'YES' please give full details:

17. Have you ever been Insured for Medical Professional Liability or maintained membership of any Defence Organisation?

YES ☐ NO ☐

If 'YES' please state:

i) The name of the Defence Organisation/s or Underwriter:

ii) The Insurance period/s or the period/s of your membership:

iii) The limits of liability provided (if applicable):

iv) Has any application for this type of Insurance cover or membership of a Defence Body ever been:

a) declined? YES ☐ NO ☐

b) cancelled? YES ☐ NO ☐

c) required special terms? YES ☐ NO ☐

If 'YES' please give full details:

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PREVIOUS CLAIMS HISTORY

18. i) List all claims made against the Proposer during the last 10 years. **IF NONE, PLEASE STATE "NONE"**:

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

ii) List all circumstances/complaints which may give rise to a claim being made against the Proposer. **IF NONE, PLEASE STATE "NONE"**:

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

19. i) Have all of the above in question 18 been notified to your previous Underwriters: YES ☐ NO ☐

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

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

☐ 1 million ☐ 2 million ☐ 3 million ☐ 4 million ☐ 5 million ☐ Other (please specify)

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.

NAME OF PROPOSER ______________________

(IN BLOCK CAPITALS)

SIGNATURE ______________________ Dated ______________

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ADDENDUM 1 - DENTISTRY

1. Are general anaesthetics ever administered?

YES ☐ NO ☐

If 'NO' please proceed to question 10.

2. Do you personally administer general anaesthetics?

YES ☐ NO ☐

If 'NO' please ignore questions 3 and 4.

3. Do you 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 yourself treat the patient?

YES ☐ NO ☐

5. If the answer to 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 'Anaesthetist') 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 'Anaesthetist' 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 you?

YES ☐ NO ☐

If 'NO' please indicate the type of practitioner who administers the sedation (eg Dentist or Anaesthetist):

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 / GYNAECOLOGY / 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 Anaesthetist available solely to the obstetrical department 24 hours a day?

YES ☐ NO ☐

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3. Is a second Anaesthetist on call 24 hours per day who is able to attend within 30 minutes?

YES ☐ NO ☐

4. Are facilities available to you for emergency Caesarean sections to be performed 24 hours per day?

YES ☐ NO ☐

5. Is a second Obstetrician on call 24 hours a day who is able to attend within 30 minutes?

YES ☐ NO ☐

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

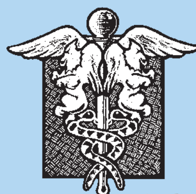
YES ☐ NO ☐

ADDENDUM 3 - OPTHALMOLOGY

Do you perform laser eye surgery? YES ☐ NO ☐

If 'YES' 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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