Medical Malpractice Insurance - Proposal Form

Insurance for your reputation

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Proposal Form for Medical Malpractice Insurance

IMPORTANT INFORMATION REGARDING COMPLETION OF THIS FORM

Method Of Completion

- This proposal form may be completed in ink or electronically, provided you print out an original and sign and date the declaration;
- ALL questions must be answered (if necessary comment as “not applicable” or “none”);
- Please review the complete document before signing and dating the declaration;
- Please post the original form to us after taking a copy for your records. A faxed or electronic copy will enable work to commence on your behalf straight away.

Presentation

- Insurers see many proposals during the course of a working day and it is therefore important that your proposal form is completed fully, clearly and accurately. First impressions really do count here;
- If there is insufficient space in the proposal form or simply to provide underwriters with a better understanding of your experience, expertise or activities, please supply additional information on your letter headed paper;
- CVs of your principals should be supplied if you have not previously been insured or if any principal has been in their current position fewer than five years;
- Standard contract conditions, brochures or other marketing material should be supplied if this helps to describe the activities undertaken or the potential professional liabilities faced;

Disclosure

- You have a legal duty to disclose to insurers all material information which may affect their judgement in determining whether to provide you with insurance and if so on what terms. In the case of renewal of existing insurance arrangements, this includes any material changes to information already disclosed to insurers;
- If you are in any doubt as to whether or not information is material, you should disclose it, even if there is no specific relevant question in the proposal form;
- It is particularly important to disclose all potential professional negligence claims that may be made against you and to notify your current underwriters of such matters as appropriate;
- Failure to disclose material information may give underwriters the right to avoid any contract of insurance they may subsequently issue, with the consequence that you will not be protected for any claims notified under that insurance.

SECTION 1. – BUSINESS PROFILE

1. NAME(S) OF INSURED/PROPOSER (including all trading names of entities to be Insured):

(Please include any predecessors for whom cover is required)

2. ADDRESS OF THE PRINCIPAL SITE: (Please list all other locations by Town or Country if overseas and identify the individual supervising at each location. Please provide on appendix sheet if required)

ALL OTHER ADDRESSES BY TOWN/COUNTRY:

Principal Contact (including title):		**Telephone Number:**	
E-Mail:			
Web-Site Address:			

3. DATE OF COMMENCEMENT OF CURRENT BUSINESS:

DATE OF COMMENCEMENT OF AND CESSATION OF FORMER BUSINESS:
(If Applicable)

REASON FOR CESSATION OF FORMER BUSINESS:

4. PARTNERS/DIRECTORS/SOLE PRACTITIONERS & CONSULTANTS:-

Names of Partners/Directors/Principal	Age	Qualifications & Professional Associations	Date Qualified	Number of Years as Partner/ Director/Sole Practitioner *

*NOTE: Please supply CVs for any Partner(s)/Director(s) or Principal with less than 5 years relevant experience.

5. Please provide a brief business description including all clinical activities:

6. TYPE OF BUSINESS – Please tick

NOT FOR PROFIT/SOCIAL ENTERPRISE/CIC		PARTNERSHIP	
GOVERNMENT ENTITY		JOINT VENTURE	
FOR PROFIT CORPORATION		PROFESSIONAL ASSOCIATION	
OTHER (Please describe)			

7. RECENT CHANGES? – During the last six years, has the name(s) of the Insured/Proposer changed or has any amalgamation or acquisition taken place, or have there been changes of Partners/Directors/Sole Practitioners? (i.e. departed, retired or deceased etc.) YES ☐ NO ☐

If **"YES"**, please give details below

8. CURRENT INSURANCE ARRANGEMENTS – Please advise

YEAR	LIMIT OF INDEMNITY £	EXCESS £	PREMIUM £	INSURER	RENEWAL DATE	BASIS OF COVER APPLYING
Current Year						☐ rrence/Claims Made ☐
1 Year Prior						☐ rrence/Claims Made ☐
2 Year Prior						☐ rrence/Claims Made ☐

PREVIOUS INSURANCE – Has any similar insurance for this Insured/Proposed or any Partner/Director/ Principal been declined, cancelled or renewal refused? YES ☐ NO ☐

If **"YES"**, please advise details

9. QUOTATIONS REQUIRED (If unsure, please contact to discuss or request "Please obtain various")

LIMIT OF INDEMNITY £				
EXCESS(ES) £				
RETROACTIVE DATE OF YOUR CURRENT POLICY		PERIOD CONTINOUSLY INSURED		YEAR(S)

Do you have a current policy in place providing cover back to your chosen Retroactive Date? YES ☐ NO ☐

***Retroactive date means - the date prior to which any work that you have carried out will not be covered against any future claims.**

SECTION 2. – MEDICAL TREATMENT RISK PROFILE

The following information forms the basis of rating your submission; please ensure you answer this section as fully and accurately as possible.

1. TURNOVER INCLUDING ALL FEES – Please Advise (for new insured(s)/proposer(s) start ups, please estimate the expected turnover/fee income)

	Actual for Last Completed Financial Year	Estimate for Current Financial Year	Estimate for Next Financial Year
Work Carried Out For UK Clients	£	£	£
Word Carried Out For US/Canadian Clients *Not* Subject To US/Canadian Law	£	£	£

Work Carried Out For US/Canadian Clients Subject To US/Canadian Law	£	£	£
All Other Work	£	£	£

Total	£	£	£
Operating Profit	£	£	£

PLEASE STATE THE DATE OF YOUR FINANCIAL YEAR END:	

Are you in possession of all relevant licences and/or registrations as required by law or from the applicable regulatory body for the services you provide? YES ☐ NO ☐

If **"NO"**, please give details below

2. BREAKDOWN OF ACTIVITIES

Split of patient visits/ procedures in the last 12 months and the next 12 months or if a new firm, your anticipated figures.

Medical Treatment/Services				
Category	**Description of Services**	**Exposure Base**	**Last 12 Months**	**Next 12 Months**
GP Led Primary Care (For registered patients)		No of Appointments		
Equitable Access Primary Care/Minor Injuries Unit/Walk in Centre**		No of Patient Contacts/Visits		
In-Hours GP Home Health Visiting		No of Patient Contacts/Visits		
Prison/Immigration Healthcare		No of Patient Contacts/Visits		
Unscheduled/Urgent Care (In Hours)		No of Patient Contacts/Visits		
Unscheduled/Urgent Care (Out of Hours)*		No of Patient Contacts/Visits		
Dental Services		No of Patient Contacts/Visits		
NHS111/Telephone Triage		No of Calls		
Diagnostic/Imaging Services		Receipts (£)		
Pharmacy Services		Receipts (£)		
Opticians/Optometry		Receipts (£)		
Pathology Laboratory*		Receipts (£)		
Occupational Health/Health Screening/Wellbeing Services		No of Patient Contacts/Visits		
Home Health/Domiciliary Care		No of Patient Contacts/Visits		
Rehabilitation/Counselling Services		No of Patient Contacts/Visits		
Specialist Clinic		No of Patient Contacts/Visits		
Elective/Cosmetic Surgery*		No of Procedures		

Non Elective/Cosmetic Surgery Centre*		No of Procedures		
Medical Staffing Agency		No of Staff Day Placements		
Other (Please Specify):		Please Specify:		

*Please complete the relevant Supplementary Questionnaire
**Please state any registered patient appointments under the 'GP Led Primary Care' Section above.

Please state your patient population

Please state (where applicable) the size of your registered patient list

Do you provide any telehealth or telemedicine services (including telephone triage)? YES ☐ NO ☐

If **"YES"**, please give details below

Do you undertake any antenatal/obstetric ultrasound scanning? YES ☐ NO ☐

If **"YES"**, please give details below

What percentage of your clinical work involves Paediatric patients?

Do you provide any Out of Hours services in relation to any of the activities noted under Breakdown of Activities? YES ☐ NO ☐

If **"YES"**, please give details below

Please advise where you provide medical services

Your Own Site(s)	%	**Patient's Home**		%
Long Term Care Facility	%	**Hospital**		%
Mobile Facility	%	**Schools**		%
Prison/Immigration Centre	%	**Other (Please Specify)**		%

Have any activities been discontinued in the last 6 years or do you anticipate any new activities to be undertaken in the next 12 months? YES ☐ NO ☐

If **"YES"**, please give details below

Do you provide any treatment or services under a contract that contains any specific insurance requirements? eg. PCT contracts or other contracts requesting specific policy limits, subrogation waivers etc. YES ☐ NO ☐

If **"YES"**, please give details below and attach a copy of the contract(s)

Do you provide training to anyone other than your own employees? YES ☐ NO ☐

If **"YES"**, please give details below

Name of Trainer	Qualifications	Training Course	Name of Accreditation Body	Revenue
				£
				£
				£

Do you own or operate X-ray equipment? YES ☐ NO ☐

If **"YES"**, please give details below

Equipment Use	Number of Machines	Classification of User (See People Section Below)
X-ray diagnosis only		
X-ray treatment only		
X-ray diagnosis and treatment		

Do you provide maternity or obstetrics facilities or maintain an assisted conception unit? YES ☐ NO ☐

If **"YES"**, please give details below

Do you undertake clinical trials? YES ☐ NO ☐

If **"YES"**, please give details below

Do you promote or publish any advice; or information; or give any diagnosis; or treatment of any type over the Internet or via any computer; or any electronic system accessible outside of your premises? YES ☐ NO ☐

Do you provide any of the above services outside of the UK? YES ☐ NO ☐

If **"YES"**, to either of the above please give details below

Do you provide facilities for the sterilisation of instruments in accordance with current guidelines and ensure effective cross-infection control methods are employed? YES ☐ NO ☐

Do you have a protocol for needle stick injuries? YES ☐ NO ☐

If **"NO"**, to either of the above please give details below

3. BREAKDOWN OF MEDICAL TREATMENT/SERVICES PERSONNEL

Please provide the total headcount and FTE of staff involved in the following capacities, projected over the forthcoming 12 months

People				
Registered Medical/Dental Practitioners:				
Specialty (eg. GP, Radiologist etc)	**Total Headcount**	**Full Time Equivalent (Employed)**	**Full Time Equivalent (Self-Employed)**	**Cover Required For Self-Employed Individuals?**
				YES ☐ NO ☐
				YES ☐ NO ☐
Other Healthcare Professionals				
Category	**Total Headcount**	**Full Time Equivalent (Employed)**	**Full Time Equivalent (Self-Employed)**	**Cover Required For Self-Employed Individuals?**
Nurse Prescriber/Advanced Nurse/Practitioner/Nurse Clinician				YES ☐ NO ☐
Nurse Practitioner (Non-Prescriber)				YES ☐ NO ☐
Midwife				YES ☐ NO ☐
Emergency Care Practitioner				YES ☐ NO ☐
Triage Nurse				YES ☐ NO ☐
Practice Nurse				YES ☐ NO ☐
HCA/Phlebotomist				YES ☐ NO ☐
Non-Clinically Trained Call Handlers				YES ☐ NO ☐
Pharmacist				YES ☐ NO ☐
Paramedic				YES ☐ NO ☐
Radiographer/Sonographer				YES ☐ NO ☐
Physiotherapist				YES ☐ NO ☐
Audiologist				YES ☐ NO ☐
Optomoetrist/Optician				YES ☐ NO ☐
Therapist				YES ☐ NO ☐
Other Allied Healthcare Professional (Please Specify):				YES ☐ NO ☐
Other Work Not Specified Above (Please provide details of activities undertaken)				YES ☐ NO ☐
TOTAL				

*Please provide details of Other Allied Healthcare Professionals in the Additional Information box at the end of this form.

Do you record that all professional practitioners hold valid licences to practice in their specialisations issued by the relevant lawfully established and recognised licensing authority in the appropriate territory? YES ☐ NO ☐

If **"NO"**, please give details below

Do you ensure and record that **all** employed &/or engaged Medical &/or Dental Practitioners are:-

a) Members of a Medical or Dental Defence Organisation and are fully indemnified by that organisation for the professional practice undertaken on your behalf **or**

b) fully insured for their own malpractice and any acts, errors or omissions with a Limit of Indemnity of no less than £10,000,000? YES ☐ NO ☐

If **"NO"**, please give details below

Do you require all other self-employed individuals who work or provide services from your premises or who may expose you to potential claims to carry their own cover? YES ☐ NO ☐

If **"NO"**, please give details below

Do you obtain references and Disclosure and Barring Service (DBS) checks (formally criminal records bureau) for all employees and others engaged to undertake work on your behalf? YES ☐ NO ☐

If **"NO"**, please give details below

Has any professional practitioner been subject to disciplinary proceedings in the last 10 years? YES ☐ NO ☐

Has any professional practitioner ever been charged or served with a summons for any criminal offence (other than driving offences)? YES ☐ NO ☐

Has any professional practitioner ever been found guilty of a breach of any statutory obligations, by-laws or regulations? YES ☐ NO ☐

If **"YES"** to any of the previous 3 questions, please give details below

4. RECORD KEEPING

Do you maintain accurate descriptive records of all medical services and equipment used in procedures? YES ☐ NO ☐

Do you retain the records referred to above for at least 10 years from the date of treatment and, in the case of a minor, for at least 10 years after that minor attains majority? YES ☐ NO ☐

If any obstetric or maternity services are provided will you continue to retain and preserve obstetric records indefinitely? YES ☐ NO ☐

Do you maintain a record of all requests on behalf of patients for medical records? YES ☐ NO ☐

Will all medical records referred to above be made available for inspection and use, without charge, by underwriters or their appointed representatives together with any oral or written information, assistance, signed statements, evidence or depositions as required in the investigation or defence of any claim?

YES ☐ NO ☐

If **"NO"**, to any of the previous 5 questions please give details below

5. ADDITIONAL INFORMATION

Please use the space below to provide any additional information that may be material to your application.

6. CLAIMS &/OR CIRCUMSTANCES

PLEASE NOTE: IT IS IMPERATIVE THAT SECTION (A) AND (B) OF THIS QUESTION ARE ANSWERED CORRECTLY AS FAILURE TO DO SO COULD PREJUDICE YOUR RIGHTS UNDER YOUR MEDICAL MALPRACTICE INSURANCE. WHERE NECESSARY, PLEASE PROVIDE DETAILS ON AN APPENDIX SHEET.

(a) CLAIMS &/OR CIRCUMSTANCES NOTIFIED TO INSURERS

YES ☐ NO ☐

During the last ten years, has the Insured/Proposer notified to Medical Malpractice Insurers;

i) any claims that have been made against the Insured/Proposer listed in Question 1 Section 1, or against any present or former principals or employees of the Insured/Proposer ;

ii) any circumstances of which you were aware that could be/could have been potential claims against the Insured/Proposer, or against any present or former principals or employees of the Insured/Proposer;

If "YES", please provide details below:

Claim Status: (Open/Closed)	Date of Notification:	Brief Details of the Claim/Circumstance:	Amounts Paid by Insurers:	Outstanding Reserves:
			£	£
			£	£
			£	£

(b) OTHER CLAIMS &/OR CIRCUMSTANCES

After enquiry of all principals and professional staff of the Insured/Proposer, are you aware of any other claims and/or circumstances that may give rise to claims against the Insured/Proposer, and which have not yet been notified to insurers?

YES ☐ NO ☐

If "YES", please provide full details including amounts involved

(c) DISHONESTY

Have you suffered any loss from the dishonesty or malice of any partner, director, employee or self-employed freelancer or do you have any grounds, after reasonable enquiry, for suspecting that such a person has acted dishonestly or maliciously?

YES ☐ NO ☐

If "YES", please provide full details including amounts involved

DECLARATION

I/We declare that the above statements and particulars are to the best of my/our belief true and I/We have not suppressed or mis-stated any material facts.

I/We agree that this proposal, together with any other information supplied by me/us shall form the basis of any subsequent contract of insurance.

I/We agree that where information has been inserted on our behalf, we have reviewed such information and confirm the information is accurate and correct

Signed:

Print Name:

Position in Company

For and on behalf of:

Date:

MFL Professional
INSURANCE BROKERS

MFL Affinity

MFL Science & Technology
INSURANCE BROKERS

PI Manager
PROFESSIONAL LIABILITY RISK CONTROL

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