Camargue

HOSPITALS
PROPOSAL FORM

MEDICAL MALPRACTICE

INSTRUCTIONS

- This application form must be completed clearly using blue or black ink
- It is the duty of the applicant to disclose all material facts. For the purposes of this application form, a material fact is deemed to be information that would be likely to influence an underwriter's judgement and/or acceptance of the risk to be insured.
- Each section of the application form must be completed in full. Incomplete or unsigned forms will not be accepted.
- It is the responsibility of the applicant to notify any change of address or any change to any other relevant circumstances.
- Once completed, please sign and date the application form and return it to the applicant's appointed insurance broker/advisor.
- Should there be insufficient room in this application form for details, please use the blank page marked 'Section 8 – Additional Information' at the back of the form to record the answers, noting the appropriate question number.
- Upon acceptance of the underwriters' terms and conditions and payment of the premium, all information provided by the applicant, together with these guidance notes, will be deemed to be incorporated in the contract between underwriters and the insured.
- The signing of this application form does not bind the applicant or underwriters to complete a contract of insurance.
- Should the applicant have any questions, he/she should contact the applicant's appointed insurance broker/advisor.

1 | General Information

Details of entities to be insured (the "Proposer")

Proposer's Name: Date of Birth: / /

ID number (if Sole Trader):

Physical Address:

Postal Code:

Practice/Trading Address/es if different from the above:

Company Reg No: VAT No:

Date Company Established / Services Commenced: / /
As currently constituted

Date Company Established / Services Commenced: / /
As initially established:

Contact Name: Contact number:

Email: Website:

Company Legal Constitution: Partnership / Private Company / Public Company / Close Corporation / Non-profit Organisation / Government / Sole Proprietor

AUTHORISED FINANCIAL SERVICES PROVIDER, LICENCE NUMBER: 6344. APPROVED LLOYD'S COVERHOLDER PIN: 107824DRW
Camargue Underwriting Managers (Pty) Ltd. Co. Reg. No. 2000/028098/07.
33 Glenhove Road, Melrose Estate, 2196. Postnet Suite 250, Private Bag X4, Bedfordview 2008
Telephone: 011 778 9140, Facsimile: 011 778 9199, E-mail: camargue@camargueum.co.za, Website: www.camargueum.co.za

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2 | Professional Services

1. **During the last 6 years, please provide details of any major changes to the applicant's clinical services.**

2. **During the last 6 years, please provide details of any changes to the applicant's name(s), or any amalgamations or acquisitions which have taken place, or any major changes to the executive leadership.**

3. **Where does the applicant provide services to their clients? (please tick all appropriate boxes):**

	Trading address(es)/applicant's premises		Long term care facility
	Third party hospital/clinic		Patients' homes
	Prison/immigration centre		School(s)
	Third party medical teaching facility		Laboratory
	Mobile facility		

4. **Please state the following financial information relating to the applicant's business (a copy of the latest financial statements may be required)**

4.1 When was your immediate past financial year end:

PLEASE STATE	LAST YEAR	CURRENT YEAR ESTIMATE	FORTHCOMING FINANCIAL YEAR
Gross Revenue from Fees	R	R	R
Gross Revenue from any other source (provide brief details on a separate page)	R	R	R
Total Revenue	R	R	R

5. **Are there any major changes to the business planned in the forthcoming year? (If yes, please provide full details)**

6. **Does the applicant sell or distribute any medical/pharmaceutical products and/or medical devices? (Not including those used on or by patients in the course of their treatment by the applicant)** YES NO

7. **Does the applicant manufacture, alter, re-label, mix or blend products/devices in any way?** YES NO

8. **If yes to questions 6 or 7 above, what was the gross income generated from these activities:**

COUNTRY OF SALE	CURRENCY	LAST FINANCIAL YEAR (ACTUAL)	CURRENT FINANCIAL YEAR (ESTIMATE)	NEXT FINANCIAL YEAR (BUDGET)

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9. Please tick all applicable services provided at your facilities (please note this does not constitute a comprehensive list of all medical/surgical specialties/departments):

	Abortion Clinic/Termination of Pregnancy*		Neonatal ICU/Paediatric ICU
	Ambulance*		Neurosurgery
	Anaesthesiology*		Neurological ICU
	Assisted Conception*		Obstetrics & Midwifery*
	Bariatric Surgery*		Oncology
	Blood/Sperm/Tissue Bank*		Ophthalmology
	Burns Unit		Pathology
	Diagnostic Cardiology		Paediatrics
	Interventional Cardiology		Pharmacy*
	Cardiothoracic Surgery		Plastic/Cosmetic Surgery
	Coronary Care Unit (CCU)		Psychiatry
	Clinical Research/Clinical Trials*		Radiation Therapy
	Day Care		Diagnostic Radiology
	Dentistry		Interventional Radiology
	Emergency Services*		Rehabilitation/Physical Therapy
	Euthanasia		Robotic Surgery
	Family Practice/Primary Care		Surgery – Inpatient*
	Genetic Medicine		Surgery – Outpatient*
	Home Health/Domiciliary Care		Telemedicine*
	Infectious Disease Medicine		Transplant Surgery*
	Intensive Care Unit (ICU)		Other (please specify)
	Long Term Care		Other (please specify)

* Denotes further information required below if ticked:

10. ABORTION CLINIC / TERMINATION OF PREGNANCY

a. Please state the number of terminations carried out in the last 12 months
b. Please state the % split as follows:

GESTATION	MEDICAL %	SURGICAL %
Less than 15 weeks		
15 – 20 weeks		
More than 20 weeks		

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11. AMBULANCE SERVICES

a. Are ambulances used as

i. First responders — YES ☐ NO ☐

ii. Patient transport — YES ☐ NO ☐

b. Please state the number of owned/operated ambulances

c. Please state the number of owned/operated air ambulances

d. Please state the number of movements in the last 12 months by type:

TYPE	NUMBER
Emergency	
Non-emergency	
Perinatal/Neonatal/Paediatric	

12. ANAESTHESIOLOGY

a. Do you use nurse anaesthetists? — YES ☐ NO ☐

If yes,
i. Do they carry separate insurance? — YES ☐ NO ☐

ii. Are nurse anaesthetists or any other practitioners assisting during anaesthesia care supervised by a qualified anaesthesiologist at all times? — YES ☐ NO ☐

b. Do you ensure that there is a fully qualified anaesthesiologist on site at all times? — YES ☐ NO ☐

13. ASSISTED CONCEPTION

a. Is all donor semen screened, cryopreserved and quarantined in line with current HFEA standards and guidelines or equivalent regulatory authority codes of practice? — YES ☐ NO ☐

14. BARIATRIC SURGERY

a. Please state the number of weight loss operations performed in last 12 months by type as follows: — YES ☐ NO ☐

TYPE	NUMBER
Gastric Bypass	
Gastric Band	
Gastric Balloon	
Bilopancreatic Diversion	
Other (please specify)	

a. Do you provide bariatric services to patients under 18 years of age? — YES ☐ NO ☐

b. Does your bariatric programme have specific patient exclusion criteria? — YES ☐ NO ☐

c. Do you always obtain signed informed consent from patients prior to performing bariatric procedures? ? — YES ☐ NO ☐

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d. Please state the minimum length of time which potential bariatric patients must undergo counselling and weight loss assistance prior to surgery.

15. BLOOD / SPERM / TISSUE BANK

a. Is any blood, blood product, or other human tissue bought or obtained from outside your principal country of operation? **YES** **NO**

if yes, please specify

.....

b. Are all blood or blood products tested before use? **YES** **NO**

c. Do you outsource any of your blood tests? **YES** **NO**

i. if yes, do you contractually require the outsourcing company to carry suitable professional liability insurance? **YES** **NO**

16. CLINICAL TRIALS

a. Please state the number of trials (and the corresponding number of trial subjects) carried out in the last 12 months and estimated for the forthcoming 12 months:

Total No. Trials (last 12 months)		Total No. Trials (next 12 months)	
Total No. Subjects (last 12 months)		Total No. Subjects (next 12 months)	

b. Are all your clinical trials carried out at your premises? **YES** **NO**

If no please specify

.....

c. Do you have written procedure sin place governing the conduct of research? **YES** **NO**

d. Do you receive full indemnity from your principals? **YES** **NO**

e. Is each prospective trial subject to a full risk analysis? **YES** **NO**

f. Are you involved in any trials or investigations involving products or substances which have been withdrawn or unlicensed by any regulatory authority? **YES** **NO**

g. Do all trial subjects sign an informed consent form prior to participation in a trial? **YES** **NO**

h. Do you conduct any form of research, testing or experimental activities in the following categories?

Transplants	
Artificial organs	
Surgery	
Human Embryo	
Genetics	
Obstetric	
Non-terminal Paediatric conditions	

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17. EMERGENCY SERVICES

a. Do you provide 24/7 on-site attending emergency medicine physician/registrar coverage at all sites with an emergency department? YES ☐ NO ☐

b. Please state your average wait time over the last 12 months (in minutes). ☐

c. Do any of the emergency department staff routinely work more than a 12 hour shift? YES ☐ NO ☐

d. Do you attempt to follow up with all patients who leave the emergency department against medical advice or without being seen by a clinician? YES ☐ NO ☐

18. OBSTETRICS & MIDWIFERY

Please state the number of deliveries by type as follows:

YEAR	STATUS	VAGINAL	CAESAREAN (MEDICALLY NECESSARY)	CAESAREAN (EMERGENCY)	CAESAREAN (ELECTIVE)	VBAC	TOTAL
Last 12 months (Actual)	Live						
	Still						
Next 12 months (Estimate)	Live						
	Still						

a. Is continuous electronic foetal monitoring performed on all patients in active labour? YES ☐ NO ☐

b. Do you provide 24/7 on-site attending Obstetrician coverage at all sites with a maternity department? YES ☐ NO ☐

c. Is an attending Obstetrician required to review all foetal monitoring strips periodically during labour and delivery? YES ☐ NO ☐

d. Can caesarean sections be performed within 30 minutes 24 hours per day? YES ☐ NO ☐

e. Are you responsible for any home births or births performed outside your hospital premises? YES ☐ NO ☐

if Yes please provide details

.....

f. Do you provide midwife-led birthing? YES ☐ NO ☐

If yes

i. Please state approximate % of midwife-led deliveries ☐ %

g. Do you conduct any high-risk birthing programmes (eg high gestational weight, breached vaginal delivery, multiples etc)? YES ☐ NO ☐

h. Do you use any form of obstetrical simulation training? YES ☐ NO ☐

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19. PHARMACY

a. Do you provide pharmacy services to third party organisations? YES ☐ NO ☐

If yes,

i. Please state revenue generated from this service

.....

b. Do you have written procedures for pharmacy safety control / risk management? YES ☐ NO ☐

c. Please confirm if a pharmacist is on-site 24/7 YES ☐ NO ☐

d. Do you have any medication error reduction technology in use (eg barcoding systems) in place? YES ☐ NO ☐

e. Are you incompliance with all applicable regulatory laws governing the manufacture, control dispensing and distribution of prescription medication? YES ☐ NO ☐

20. SURGERY

a. Please list all surgical specialties practiced at your facilities:

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b. Are any of your facilities designated referral centres for any surgical service YES ☐ NO ☐

if yes, please specify

.....

c. Can a house officer or resident perform surgery under general anaesthetic without an attending surgeon being present? YES ☐ NO ☐

d. Do both surgeon and anaesthetist conduct informed consent counselling with the patient in person prior to surgery? YES ☐ NO ☐

e. Do both surgeon and anaesthetist always obtain signed informed consent from patients prior to surgery? YES ☐ NO ☐

f. Are patients provided with written material routinely as part of the consent procedure? YES ☐ NO ☐

g. Do you use any of the following:

Surgical checklists	
Simulation training	
Pre-operative 'time-outs'	
Manual sponge counts	
UV light environmental disinfection	
Instrument tray barcode scanning	

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21. TELEMEDICINE

a. Do you provide primary (patient to doctor) or secondary (doctor to doctor) telemedicine? **YES** ☐ **NO** ☐

b. Please list the countries from which patients can access your telemedicine services.

.....

.....

c. Please list the countries from which clinicians can conduct telemedicine services on your behalf.

.....

.....

d. Please state the number of telemedicine interactions in the last 12 months. ☐

e. Do all providers use standardised clinical protocols when conducting telemedicine consultations? **YES** ☐ **NO** ☐

f. Do you contractually require that institutions to whom you provide secondary telemedicine services indemnify you? **YES** ☐ **NO** ☐

22. TRANSPLANT SURGERY

a. Please list all types of transplants and the corresponding number undertaken in the last 12 months.

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b. Please confirm that you are fully licensed and accredited by the appropriate regulatory body. Ie. National Hospitals Network (NHN)

.....

.....

c. Do you accept presumed consent (opt-out) donors? **YES** ☐ **NO** ☐

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3 | EXPOSURE INFORMATION

Please complete the following tables as complete as possible with the most accurate and up to date information available. If possible complete the information applicable to the policy period for which cover is sought. **Providing this information separately in MS Excel format is preferred.**

1. Please complete the following information for all types of inpatient beds:

	LICENCED	OCCUPIED				
BED TYPE	**CURRENT YEAR**	**PRIOR YEAR -2**	**PRIOR YEAR -1**	**PRIOR YEAR**	**CURRENT YEAR**	**NEXT YEAR (ESTIMATE)**
Acute Medical/Surgical						
Obstetric						
Bassinet						
Paediatric						
ICU						
NICU/PICU						
Psychiatric						
Rehabilitation						
Skilled Nursing						
Assisted Living						
Independent Living						
Extended Care						
Hospice Care						
Day Care						
Other (specify)						

2. Please complete the following information for all types patient visits:

TYPE OF VISIT/PROCEDURE	**CURRENT YEAR**	**PRIOR YEAR -2**	**PRIOR YEAR -1**	**PRIOR YEAR**	**CURRENT YEAR**	**NEXT YEAR (ESTIMATE)**
Emergency Department visits						
Urgent Care visits						
Inpatient Surgeries						
Outpatient Surgeries						
Births						
Home Health visits (professional)						
Home Health visits (non-professional)						
Outpatient Clinic visits						
Other Outpatient visits						
Other (specify)						

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4 | STAFF COMPLEMENT

1. Please list the Full Time Equivalent (being 40 hours per week) of the personnel working for, or on behalf of the applicant WHO REQUIRE COVERAGE UNDER THIS INSURANCE POLICY.

Registered Medical Practitioners:

SPECIALTY (EG CARDIOLOGIST, RADIOLOGIST ETC)	TOTAL HEADCOUNT	FTE (EMPLOYED)	FTE (SELF EMPLOYED)	FTE (LOCUM / BANK STAFF)

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Other medical Staff:

CATEGORY	TOTAL HEADCOUNT	FTE (EMPLOYED)	FTE (SELF EMPLOYED)	FTE (LOCUM / BANK STAFF)
Registered Nurses				
Nurse Practitioners				
Nurse Midwives				
Nurse Anaesthetists				
Pharmacists				
Lab Technicians				
Surgical Technicians				
Physicians Assistants				
Allied Health Professionals				
Paramedics				
Complementary Therapists				
Other (specify)				
Other (specify)				

2. Have staffing numbers changed significantly in the past 5 years? YES NO

3. Do you require that all professionally qualified clinical staff:

   a. Are registered with or licenced by the relevant regulatory/licencing/registration body? YES NO

   b. Are adequately trained and competent in their role? YES NO

   c. Are adequately supervised under the appropriate management? YES NO

   d. Are re-credentialed on at least an annual basis? YES NO

   If no, please state how often re-credentialing takes place.

4. Do you require that all non-employed medical staff:

   e. Carry their own medical professional liability insurance or maintain indemnity via a medical defence organisation? (Please specify minimum limits of indemnity)

   .....

   f. Provide evidence of this coverage on an annual basis as part of your privileging/ re-credentialing process? YES NO

5. Do you also ensure and record that all registered medical/dental practitioners hold valid licences to practice in their specialisations issued by the relevant lawfully established and recognised licencing authority in the appropriate territory? YES NO

6. In respect of all personnel, does the applicant provide an induction programme and employee handbook in every case? YES NO

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7. Do you have formal procedures for ensuring that all personnel are provided with:

g. Formal training	YES	NO
h. Supervision where necessary	YES	NO
i. Continuing education for permanent members of staff	YES	NO
j. Appraisal / assessment for permanent members of staff	YES	NO
k. A confidentiality clause included in their contract / terms of service	YES	NO

5 | RISK MANAGEMENT AND QUALITY ASSSURANCE

1. Do you have a documented Risk Management programme?	YES	NO

2. Do you adopt the following quality controls and risk management procedures:

a. Are there protocols in place for the management of standard, frequently encountered conditions?	YES	NO
b. Is there a system of ongoing audit to ensure compliance with protocols?	YES	NO
c. Is there a formal complaints procedure?	YES	NO
d. Is there a system for the reporting and investigation of adverse / significant events?	YES	NO
e. Is there a health and safety policy?	YES	NO
f. Is there periodical Health & Safety training for all personnel (eg manual handling)?	YES	NO
g. Is there a protocol to ensure that good quality, contemporaneous medical records are made after all clinical contacts with patients (including telephone contacts)?	YES	NO
h. Have you had a risk assessment carried out by an independent organisation within the last 3 years?	YES	NO
i. Are there procedures in place for the checking and maintenance of clinical equipment or devices owned by the applicant?	YES	NO
j. Are leased clinical equipment or devices regularly checked and maintained by the supplier?	YES	NO
k. Are there formal arrangements in place for communicating with a referred patient's Primary Care physician for each assessment of their treatment?	YES	NO
3. Do you provide facilities for the sterilisation of instruments in accordance with current guidelines?	YES	NO
4. Do you comply with the current guidelines for the safe collection and disposal of any clinical/medical waste products?	YES	NO
5. Do you have a protocol for needle stick injuries?	YES	NO

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6. Are your medical records:

a. Paper **YES** ☐ **NO** ☐ b. Electronic **YES** ☐ **NO** ☐ c. Both **YES** ☐ **NO** ☐

7. Do you maintain, and continue to maintain accurate and descriptive records of all medical services provided for a specified period of time as determined by the Department of Health, HSE or equivalent guidelines? **YES** ☐ **NO** ☐

8. Do you have a formal programme for clinical quality assurance? **YES** ☐ **NO** ☐

9. Please comment below on how clinical quality is maintained in line with best practice within your industry and how this is benchmarked against your peers:

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6 | INDEMNITY INFORMATION

1. Please provide details of the applicant's current arrangements for Medical Malpractice and Public Liability Insurance:

			MEDICAL PROFESSIONAL LIABILITY		GENERAL LIABILITY		
INCEPTION DATE	PERIOD OF COVER	INSURER	LIMIT OF LIABILITY	EXCESS	LIMIT OF LIABILITY	EXCESS	PREMIUM

2. Has prior cover been continuously maintained on a 'claims made' basis? **YES** ☐ **NO** ☐

If yes:

a. Please state the current retroactive date on your policy:

.....

3. Requested cover – please State the LIMIT OF INDEMNITY and EXCESS required:

Limit	R	R	R
Excess	R	R	R

4. Please state the date on which the applicant requires insurance coverage to commence:

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7 | CLAIMS HISTORY AND PUNITIVE MEASURES DECLARATION

1. Do you:

   a. Manage claims in-house? **YES** ☐ **NO** ☐

   b. Use a Third Part Administrator? **YES** ☐ **NO** ☐

   (if yes, please provide details)

   .....

2. Please provide the following details in relation to the applicant's business:

   Is the applicant currently aware of, or has the applicant ever been aware of in the past, either wholly or in part, either in the UK, Ireland or abroad, any of the following: (For the purposes of this declaration, 'the applicant' means the entity(s) to be insured, including any past or present staff whilst working for or on behalf of such entity)

   a. Any claim, circumstance, complaint or proceedings brought or threatened against the applicant, or any incident which could lead to such a claim, circumstance, complaint or proceedings (this includes written or verbal complaints or expressions of dissatisfaction against the applicant or connected with the applicant)? **YES** ☐ **NO** ☐

   b. Any investigation or adverse finding by any professional body, tribunal, regulatory or registration body? **YES** ☐ **NO** ☐

   c. Any disciplinary action? **YES** ☐ **NO** ☐

   d. Any conditions imposed on, suspension of, or revocation of the applicant's licence or registration? **YES** ☐ **NO** ☐

   e. Any criminal offence or formal police caution? **YES** ☐ **NO** ☐

   f. Commencement of any medical defence organisation's 'adverse member procedure'? **YES** ☐ **NO** ☐

   g. Declinature, termination, non-renewal or special conditions imposed by previous or current insurers? **YES** ☐ **NO** ☐

3. If you have answered yes to any part of above question, please provide details below:

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Telephone: 011 778 9140, Facsimile: 011 778 9199, E-mail: camargue@camargueum.co.za, Website: www.camargueum.co.za

Underwritten by certain underwriters at Lloyd's and Compass Insurance Company Limited

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8 | ADDITIONAL INFORMATION

1. Please attach as much of the following additional information as possible in order to enable underwriters to fully assess the risk to be insured:

   a. Schedule of named insureds
   b. Schedule of employed physicians
   c. Latest financial statements
   d. Organisational chart
   e. 10 year loss run (in excel format, gross of any deductible/excess/Self Insured Retention) in accordance with the attached template
   f. Actuarial report if available
   g. Latest accreditation/licencing/regulatory report if available

2. Please use the space below to provide additional information to any of the questions in this application form or any further information which you consider relevant/material.

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AUTHORISED FINANCIAL SERVICES PROVIDER, LICENCE NUMBER: 6344. APPROVED LLOYD'S COVERHOLDER PIN: 107824DRW
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DECLARATION

Signing this proposal form binds neither the proposer to complete this insurance, nor does it bind the insurer to accept the proposal. It is agreed that all written statements and attachments furnished to the insurer in conjunction with this proposal are hereby incorporated by reference into this proposal and made part thereof. It is understood and agreed that the insurer has relied upon this proposal and attachments, which shall be the basis of the insurance contract.

The undersigned is an authorised signatory of the Proposer and certifies that reasonable inquiry has been made to obtain the answers herein which are true, correct and complete to the best of his/her knowledge and belief. We undertake to inform the insurer of any material alteration to these facts, whether occuring before or after completion of the insurance contract

NAME | **CAPACITY**

SIGNATURE OF THE PROPOSER | **DATE** DD/MM/YYYY

BROKER DETAILS

Broker:

Contact Person: | Tel:

Email: | Fax number:

THE POWER OF KNOWLEDGE