



MEDICAL MALPRACTICE Hospitals Proposal Form

IMPORTANT NOTICE

- Answer all questions leaving no blank spaces.
- If you have insufficient space to complete any of your answers, continue on your headed paper.
- It is the intention of Underwriters that any Contract of Insurance with the Proposer shall be based upon the answers and information provided in this Proposal Form and any other additional information provided by the Proposer. If a quotation is offered it will be the intention of Underwriters to offer coverage only in respect of those entities named in answer to Question 1.
- Completion of this form does not bind the Proposer or Insurer to complete the insurance transaction.

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 occurring before or after completion of the insurance contract.

Privacy Statement

I/We consent to Camargue Underwriting Managers processing my/our personal information as per the Privacy Statement which may be accessed here <https://www.camargueum.co.za/legal>

.....
NAME

.....
CAPACITY

.....
SIGNATURE OF THE PROPOSER

.....
DATE DD/MM/YYYY

BROKER DETAILS

Broker:
.....

Contact Person:
.....

Tel:
.....

Email:
.....

Fax number:
.....

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

UNDERWRITTEN BY THE LICENSED INSURERS:

Compass Insurance Company Limited
Co. Reg. No. 1994/003010/06
FSP (12148)



MEDICAL MALPRACTICE Hospitals Proposal Form

1 | GENERAL INFORMATION

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

Proposer's Name: _____ Date of Birth: / /

ID number (if Sole Trader): _____

Trading Name (if different from above): _____

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

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	<input type="checkbox"/>	Long term care facility	<input type="checkbox"/>
Third party hospital/clinic	<input type="checkbox"/>	Patients' homes	<input type="checkbox"/>
Prison/immigration centre	<input type="checkbox"/>	School(s)	<input type="checkbox"/>
Third party medical teaching facility	<input type="checkbox"/>	Laboratory	<input type="checkbox"/>
Mobile facility	<input type="checkbox"/>		<input type="checkbox"/>

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

a) When was your immediate past financial year end?

	PREVIOUS FINANCIAL YEAR	LAST FINANCIAL YEAR	CURRENT FINANCIAL YEAR ESTIMATE
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

* Previous Financial Year represents the completed financial year that occurred before the most recent completed financial year.

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

7. Does the applicant manufacture, alter, re-label, mix or blend products/devices in any way?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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

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

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		

11. Ambulance Services

- a) Are ambulances used as

i. First responders

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

ii. Patient transport

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

- 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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If yes,

- i. Do they carry separate insurance?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

- ii. Are nurse anaesthetists or any other practitioners assisting during anaesthesia care supervised by a qualified anaesthesiologist at all times?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

- b) Do you ensure that there is a fully qualified anaesthesiologist on site at all times?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

14. Bariatric Surgery

a) Please state the number of weight loss operations performed in last 12 months by type as follows:

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

- b) Do you provide bariatric services to patients under 18 years of age? YES NO
- c) Does your bariatric programme have specific patient exclusion criteria? YES NO
- d) Do you always obtain signed informed consent from patients prior to performing bariatric procedures? YES NO
- e) 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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

if yes, please specify

.....

c) Do you have written procedure sin place governing the conduct of research?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

d) Do you receive full indemnity from your principals?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

e) Is each prospective trial subject to a full risk analysis?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

f) Are you involved in any trials or investigations involving products or substances which have been withdrawn or unlicensed by any regulatory authority?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

g) Do all trial subjects sign an informed consent form prior to participation in a trial?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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?
If Yes please provide details YES NO
-

- f) Do you provide midwife-led birthing?
If yes,
i. Please state approximate % of midwife-led deliveries YES NO
- 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

19. Pharmacy

- a) Do you provide pharmacy services to third party organisations?
If Yes, please state revenue generated from this service YES NO
-
- 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?
- e) Are you in compliance with all applicable regulatory laws governing the manufacture, control dispensing and distribution of prescription medication?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

20. Surgery

- a) Please list all surgical specialties practiced at your facilities:

- b) Are any of your facilities designated referral centres for any surgical service

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If Yes, please specify

.....

- c) Can a house officer or resident perform surgery under general anaesthetic without an attending surgeon being present?
- d) Do both surgeon and anaesthetist conduct informed consent counselling with the patient in person prior to surgery?
- e) Do both surgeon and anaesthetist always obtain signed informed consent from patients prior to surgery?
- f) Are patients provided with written material routinely as part of the consent procedure?
- g) Do you use any of the following:

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Surgical checklists	<input type="checkbox"/>
Simulation training	<input type="checkbox"/>
Pre-operative 'time-outs'	<input type="checkbox"/>
Manual sponge counts	<input type="checkbox"/>
UV light environmental disinfection	<input type="checkbox"/>
Instrument tray barcode scanning	<input type="checkbox"/>

21. Telemedicine

- a) Do you provide primary (patient to doctor) or secondary (doctor to doctor) telemedicine?
- b) Please list the countries from which patients can access your telemedicine services.

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
------------	--------------------------	-----------	--------------------------

f) Do you contractually require that institutions to whom you provide secondary telemedicine services indemnify you?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
------------	--------------------------	-----------	--------------------------

21. Transplant Surgery

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

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

c) Do you accept presumed consent (opt-out) donors?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
------------	--------------------------	-----------	--------------------------

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:

BED TYPE	LICENCED	OCCUPIED				
	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 (nonprofessional)						
Outpatient Clinic visits						
Other Outpatient visits						
Other (specify)						

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)

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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

a) Are registered with or licenced by the relevant regulatory/licencing/registration body?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Are adequately trained and competent in their role?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

c) Are adequately supervised under the appropriate management?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

d) Are re-credentialed on at least an annual basis?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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

.....

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

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

.....

b) Provide evidence of this coverage on an annual basis as part of your privileging/
re-credentialed process?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

6. In respect of all personnel, does the applicant provide an induction programme and employee handbook in every case?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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

a) Formal training

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Supervision where necessary

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

c) Continuing education for permanent members of staff

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

d) Appraisal / assessment for permanent members of staff

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

e) A confidentiality clause included in their contract / terms of service

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

5 | RISK MANAGEMENT AND QUALITY ASSURANCE

1. Do you have a documented Risk Management programme?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Is there a system of ongoing audit to ensure compliance with protocols?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

c) Is there a formal complaints procedure?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

d) Is there a system for the reporting and investigation of adverse / significant events?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

e) Is there a health and safety policy?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

f) Is there periodical Health & Safety training for all personnel (eg manual handling)?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

h) Have you had a risk assessment carried out by an independent organisation within the last 3 years?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

i) Are there procedures in place for the checking and maintenance of clinical equipment or devices owned by the applicant?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

j) Are leased clinical equipment or devices regularly checked and maintained by the supplier?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

k) Are there formal arrangements in place for communicating with a referred patient's Primary Care physician for each assessment of their treatment?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

3. Do you provide facilities for the sterilisation of instruments in accordance with current guidelines?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

4. Do you comply with the current guidelines for the safe collection and disposal of any clinical/medical waste products?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

5. Do you have a protocol for needle stick injuries?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

6. Are your medical records:

a) Paper

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Electronic

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

c) Both

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

8. Do you have a formal programme for clinical quality assurance?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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:

10. Does the applicants facilities have access to a back-up power supply should there be a partial interruption, suspension or blackout of electricity?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

6 | INDEMNITY INFORMATION

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

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

2. Has prior cover been continuously maintained on a 'claims made' basis?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If Yes, 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:

.....

7 | CLAIMS HISTORY AND PUNITIVE MEASURES DECLARATION

1. Do you:

a) Manage claims in-house?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Use a Third Party Administrator?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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, 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	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Any investigation or adverse finding by any professional body, tribunal, regulatory or registration body?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

c) Any disciplinary action?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

d) Any conditions imposed on, suspension of, or revocation of the applicant's licence or registration?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

e) Any criminal offence or formal police caution?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

f) Commencement of any medical defence organisation's 'adverse member procedure'?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

g) Declinature, termination, non-renewal or special conditions imposed by previous or current insurers?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

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

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.