INCISION

Medical Indemnity Insurance

Medical Malpractice application form

IMPORTANT NOTICE

This Proposal Form is for a "claims made" policy. A "claims made" policy provides indemnity in respect of claims first made against the Insured and notified to insurers during the period of insurance. "Claims made" policies also provide indemnity in respect of claims first made against the Insured after the period of insurance which arise from circumstances properly notified to insurers during the period of insurance.

Please complete each question fully using black or blue ink and enter "N/A" if not applicable. Any unanswered questions will delay a quotation. Should there be insufficient space on the Proposal Form to provide a complete answer or if additional information or material is necessary, additional sheets should be used and attached to this Proposal Form. Please sign and date this Proposal Form.

It is the duty of the proposed Insured to complete this Proposal Form accurately and in good faith and to disclose all material facts. Failure to comply with these obligations may result in the refusal to provide cover and the policy being cancelled. For the purpose of this Proposal Form, a "material fact" is a fact that would be likely to influence the judgment of a prudent underwriter in fixing the premium or determining whether to underwrite the risk. If you are in any doubt as to whether a fact is material, please consult with your insurance broker or intermediary.

This completed Proposal Form, together with any other information provided, shall form the basis of the contract of insurance, if entered into.

SECTION 1

	General Information	
1.1	**Please state the full legal name and address of the Insured:**	
1.2	**Website Address**	
2	**How many years has the Insured been in operation?** (If this is a new operation that is yet to start trading, please supply the business plan with the Proposal Form).	
3	**How long has the Insured been operating under the current management?**	
4	**Has the Insured ever engaged in similar services or activities under a different name?** If **Yes**, please state the full previous name(s):	Yes ☐ No ☐

5	Please provide a full description of the Insured's business services/activities for which cover is required:				
6	Please state the Insured's gross annual income (including currency) for the following:				
	The last complete financial year end:				
	The current financial year (estimate):				
7	Please state the approximate split in income between contracts originating from:				
	UK	EU	USA/Canada	Rest of the World	
	%	%	%	%	
8	Does the Insured intend to cease any existing services/activities within the next twelve (12) months			Yes ☐	No ☐
9	Does the Insured intend to commence any new services/activities within the next twelve (12) months?			Yes ☐	No ☐
10	Does the Insured have any additional locations?			Yes ☐	No ☐
11	Has the Insured merged with or demerged from any other entity in the past five (5) years?			Yes ☐	No ☐
12	Does the Insured anticipate any sale of assets, mergers, acquisitions, consolidations or change in operations, services or activities within the next twelve (12) months?			Yes ☐	No ☐
13	Has the Insured entered into any joint ventures or limited partnerships?			Yes ☐	No ☐
14	Does the Insured participate in any teaching programme or have affiliations with educational institutions?			Yes ☐	No ☐
	If you have answered **Yes** to any of questions **8 to 14** above, please provide details including the address, telephone number, contact person with title and email address of any additional locations:				

SECTION 2

	Risk Details				
1	**What services are provided by the Insured? Please indicate a percentage split of each of the services provided:**				
	Accident & Emergency	%	Hyperbaric Clinic/Services	%	
	Acquired Brain Injury Rehabilitation	%	Learning Disabilities	%	
	Addiction Treatment Centres	%	Medical Employment Agency	%	
	Alternative/ Complementary Therapy	%	Medical Repatriation	%	
	Ambulatory/Paramedic Services	%	Medical Training Institution	%	
	Antenatal Clinic	%	Nutrition/Slimming/Dietary	%	
	Beauty Therapy Clinic	%	Obstetrics and Maternity	%	
	Clinical Trials	%	Occupational Health	%	
	Cosmetic Surgery - Invasive (If yes, please complete Addendum 1)	%	Opticians/Optometry	%	
	Cosmetic - Non Surgical (If yes, please complete Addendum 1)	%	Out of Hours Primary Care Services	%	
	Counselling	%	Palliative Care	%	
	Dentistry	%	Pathology/Laboratory Services	%	
	Diagnostic and Scanning Services	%	Pharmacy	%	
	Domiciliary Care	%	Psychiatric	%	
	Elderly Care	%	Sports Medicine/Injury	%	
	Eye Surgery - Laser/Refractive Eye	%	Surgery - Minor	%	
	Eye Surgery - Other	%	Surgery - Intermediate	%	
	Fertility Services	%	Surgery - Major	%	
	GP/Primary Care Services	%	Other (please specify):		
	Health and Fitness Centre	%		%	

2 **Please state the total number of licensed beds and average daily occupancy:**

Category	Number of Licensed Beds	Average Daily Occupancy		Number of Licensed Beds	Average Daily Occupancy
Acute Care		%	ICU/ITC Beds		%
Acute Psychiatric Beds		%	Learning Disability Beds		%
Acquired Brain Injury Rehabilitation Beds		%	Nursing Home Beds		%
Addiction/Rehabilitation Treatment Beds		%	Psychiatric Rehabilitation Beds		%
Bassinets, Cribs and Cots		%	Other (please specify):		
Elderly Care Beds		%			%
Hospice/Palliative Care Beds		%			

3 **Please state the number of surgeries or visits you have in the following categories for the last completed financial year and your projection for next financial year:**

Category	Total Annual Number			Total Annual Number	
	This Financial Year	Next Financial Year		This Financial Year	Next Financial Year
Inpatient Surgeries			Home Health Visits		
Outpatient Surgeries			Clinic Visits		
Addiction Visits			ER Visits		
Rehabilitation Visits			Other (please specify):		
Physical Therapy Visits					
Psychiatric Visits					

4 **Are you duly licensed in accordance with the Care Standards Act 2000 and are you registered with the Care Quality Commission ("CQC") (or equivalent body)?** Yes ☐ No ☐

5 **Has your registration with the CQC (or equivalent body) ever been:**
a) Approved with conditions Yes ☐ No ☐
b) Cancelled Yes ☐ No ☐

6 **Have you ever been in dispute with or investigated by the CQC (or equivalent body) regarding an assessment/Inspection Report?** Yes ☐ No ☐

7 **Are there any outstanding recommendations and requirements from your last CQC (or equivalent body) Inspection Report?** Yes ☐ No ☐

8 **Does the Insured engage in telemedicine i.e. Radiology, Cardiology, Opthlamology, remote monitoring for home patients, Dematology etc?** Yes ☐ No ☐

9 **Does the Insured provide any internet based patient services?** Yes ☐ No ☐

10 **Does the Insured have a Business Continuity Plan in the event of a computer system failure, virus or malfunction?** Yes ☐ No ☐

If you have answered **Yes** to any of Questions **5** to **10** in this section, please provide details and continue on page 12 if you need more space, or attach any additional information to the proposal form.

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SECTION 3

	Staff				
1	**Please state the total number of medical practitioners involved in the following capacities:** **PLEASE NOTE:** Registered Medical Practitioners would be expected to maintain their own cover unless it is requested below. Further details including a CV and claims experience will need to be provided for cover to be considered.				
	Category	**Employed**	**Self-Employed**	**Bank/ Agency Staff**	**Cover Required?**
	Surgeons				
	- Cosmetic				Yes ☐ No ☐
	- Orthopaedic				Yes ☐ No ☐
	- Other				Yes ☐ No ☐
	Non-Procedural Physicians				
	- Psychiatrists				Yes ☐ No ☐
	- Other				Yes ☐ No ☐
	Anaesthetists				Yes ☐ No ☐
	Dentists				Yes ☐ No ☐
	Gynaecologists				Yes ☐ No ☐
	Midwives				Yes ☐ No ☐
	Obstetricians				Yes ☐ No ☐
	Registered Nurses				Yes ☐ No ☐
	Nurse Practitioners				Yes ☐ No ☐
	Paramedics				Yes ☐ No ☐
	Pharmacists				Yes ☐ No ☐
	Residential Medical Officers				Yes ☐ No ☐
	Laboratory Technicians				Yes ☐ No ☐
	Complementary Professionals				Yes ☐ No ☐
	Supplementary Professionals				Yes ☐ No ☐
	Auxiliaries				
	- Qualified				Yes ☐ No ☐
	- Not Qualified				Yes ☐ No ☐
	Social Workers				Yes ☐ No ☐
	Directors/Partners/ Principals				Yes ☐ No ☐
	Administrative				Yes ☐ No ☐
	Other (please specify):				
					Yes ☐ No ☐
					Yes ☐ No ☐

2	**Do you have a process in place to ensure that all professionally qualified healthcare staff are registered with and are subscribing members of a Medical Institute or other professional body?**	Yes ☐ No ☐
3	**Do you ensure that all professionally qualified healthcare staff carry their own medical Professional Indemnity Insurance and provide evidence of this coverage on an annual basis?**	Yes ☐ No ☐
4	**Do you ensure that all references and qualifications are taken up/checked and that all appropriate police checks are carried out on all staff (whether full time, part time, temporary or contract staff) and do you ensure that only competent and adequately trained staff are employed and that all staff are kept under proper supervision?**	Yes ☐ No ☐
	If you have answered **No** to any of the questions **2** to **4** in this section, please provide details:	
5	**Is there an annual appraisal of individual doctors based on the General Medical Council's Good Medical Practice?**	Yes ☐ No ☐
	If Yes:	
	Who is responsible to perform the annual appraisal of doctors?	
	What steps are taken to address doctor incompetence?	
	How are complaints or questions related to doctor competence managed?	

SECTION 4

	Risk Management	
	As well as answering the questions below, please supply a copy of the following documents: • Risk management/quality management/patient safety plans • Most recent annual health check by the Healthcare Commission • Any investigations conducted by the Healthcare Commission or by any regulatory body, and documentation of corrective actions taken	
1	**Is written informed consent required from all patients prior to treatment?**	Yes ☐ No ☐
2	**Does a written risk management programme exist?**	Yes ☐ No ☐
3	**How often is the risk management programme reviewed for effectiveness and/or changes?**	
4	**Who, within the organisation, is responsible for risk management? (Name and Position)**	
5	**Are medical records kept for at least ten (10) years?**	Yes ☐ No ☐
6	**Do you provide facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that anti-cross infection methods are employed?**	Yes ☐ No ☐
7	**Do you have a written protocol for needlestick injuries?**	Yes ☐ No ☐
8	**Are incidents reports tracked and trended with summarised incident data reported to the hospital board on a regular basis**	Yes ☐ No ☐
	If you have answered **No** to any of the questions **1** to **8** in this section, please provide details:	

SECTION 5

	Prior Insurance Coverage	
1	**Has any insurer ever cancelled, declined, refused to renew, restricted or surcharged the Insured's insurance coverage?**	Yes ☐ No ☐
2	**Has the Insured been uninsured for any period of time in the past ten (10) years?**	Yes ☐ No ☐
3	**Have there been any claims or complaints brought against the Insured by a member of the medical staff?**	Yes ☐ No ☐
	If you have answered **Yes** to any of the questions **1** to **3** in this section, please provide details:	
4	**Please provide details of the following in respect of the Insured's expiring policy:**	
	a) Expiration Date:	
	b) Insurer:	
	c) Limit of Indemnity: Per Claim:	Aggregate:
	d) Excess:	
	e) Expiring Premium:	
5	**Is the Insured's expiring policy on a "claims made" basis?**	Yes ☐ No ☐
6	**Does the Insured's policy include a Retroactive Date?**	Yes ☐ No ☐
	If so, please specify:	
7	**Please indicate which limit(s) of indemnity you require quotations for:**	
	a) 1,000,000 ☐ b) 2,000,000 ☐ c) 5,000,000 ☐ d) 10,000,000 ☐	
	e) Other (please specify)	
	f) Currency (please specify)	
8	**Please specify the Excess you would like to apply:**	
	N.B. The "*Limit of Indemnity*" is the maximum amount, including defence costs and other costs and expenses, for which the insurer is responsible under a policy. The "Excess" (sometimes known as the "Deductible") is the amount the Insured will have to bear in respect of each and every claim. The excess also applies to defence costs and other costs and expenses, even if the claim is successfully defended. Generally, the higher the excess, the lower the premium will be.	

SECTION 6

	Additional Information	
1	**Do you provide any training/teaching facilities?**	Yes ☐ No ☐
2	**Do you operate, in part or whole, as an NHS Independent Treatment Centre or undertake any work for the NHS where liability is covered under the Clinical Negligence Scheme for Trusts?** If **Yes**, please provide details on the additional space provided (page 12), including	Yes ☐ No ☐
3	**Do you operate under a service of contract agreement?**	Yes ☐ No ☐
	Please supply any further information that should be made known to us, in order that we may undertake a proper assessment of the risk.	

SECTION 7

	Claims Information	
1	**Have any claims or complaints been made or threatened against the Insured or any of its directors, employees or consultants in the past ten (10) years?**	Yes ☐ No ☐
2	**Are you aware of any acts, errors, omissions, incidents, events or circumstances which may give rise to a claim or complaint being made against the Insured or any of its directors, employees or consultants?**	Yes ☐ No ☐
3	**Has the Insured (or any of its directors, employees or consultants) been subject to any investigations, examinations, inquiries or other proceedings, coroners' inquest's, prosecutions or disciplinary proceedings in the past ten (10) years?**	Yes ☐ No ☐
4	**Are you aware of any acts, errors, omissions, incidents, events or circumstances which may result in an investigation, examination, inquiry or other proceedings, coroners' inquest, prosecution or disciplinary proceedings being commenced into or brought against the Insured (or any of its directors, employees or consultants)?**	Yes ☐ No ☐
	If you have answered **Yes** to any of questions **1** to **4** in this section, please provide details in the following table:	

Date of Incident	Date of Claim	Description of claim/complaint/ act/error/omission/incident/ event/circumstance	Outcome	Amount Paid (Inc. Currency)	Amount Reserved (Inc. Currency)	Total (Inc. Currency)

SECTION 8

	Declaration
	Important Notice A Director, Company Secretary or Legal Representative of the Insured must complete this Proposal Form. All questions must be answered to enable a quotation to be given. This Proposal Form must be signed and dated. **Declaration** I/we am/are authorised to complete this Proposal Form on behalf of the Insured referred to in Section 1.1 and its directors, employees and consultants. I/we are aware of the duty of fair presentation under the Insurance Act 2015 and of my/our responsibilities and those of our agents not to misstate relevant facts and to disclose all relevant facts in accordance with the requirements of the Act. I/we understand that if the duty of fair presentation is not complied with, I/we may not be able to rely upon some or all of the terms of any policy issued in reliance on this Proposal Form or other statements made by or on behalf of me/us.
	Signature
	Print name
	Capacity:
	Company/Insured:
	Dated:
	A copy of the completed Proposal Form should be retained by those signing above.

ADDITIONAL SPACE

Please use this space to record the answers to any questions for which you require additional space, noting the appropriate question number.

ADDENDUM 1: ELECTIVE COSMETIC SURGERY

1 **Please provide the split of elective cosmetic surgery offered under the following categories:**

Abdominoplasty	%	Rhinoplasty	%
Breast Surgery	%	Scalp Surgery	%
Brow Lift	%	Thighplasty	%
Face Lift	%	Thread Lift	%
Hair Transplant	%	Other (please specify):	
Laser Eye Surgery	%		%
Liposuction	%		

2 **Please provide the split of elective Non-Surgical cosmetic procedures offered under the following categories:**

Autologous Cell Therapy	%	Mesotherapy	%
Bio Skin Jetting	%	Micro-Current Treatment	%
Botulinum Toxin Injections	%	Microdermabrasion	%
Chemical Peel	%	Micropigmentation	%
Dermabrasion	%	Microsclerotherapy	%
Dermal Filler	%	Micro-Thermocoagulation Treatment	%
Electrolysis	%	Plasma Skin Rejuvenation	%
Laser Hair Removal	%	Radiofrequency Treatment	%
Light Rejuvenation Therapy	%	Other (please specify):	
Laser Skin Surfacing	%		%
Lipotherapy	%		

3 **Are all doctors/surgeons on the General Medical Council's Specialist Register for Cosmetic Surgery or the Specialist Register in the field of Surgery?** Yes ☐ No ☐

4 **Please provide details of the following for all individuals undertaking procedures/treatments:**

a) Name:	
b) Qualifications:	
c) Years of experience on cosmetic procedures:	
d) Numbers of procedures performed:	
e) Confirmation of membership of professional associations/ organisations:	

(An additional back page is provided for this information)

5	**Please provide an estimate of the percentage of patient referrals from the following:** a) GPs/Consultants: **%** b) Self-Referral: **%** c) Other (please specify): **%**
6	**Is the patient's medical history always obtained from their own GP prior to treatment?** Yes ☐ No ☐ If **No**, please provide details of the precautions taken in relation to patients that may have existing medical conditions:
7	**How are patients informed of the nature of the surgery or treatment, risks involved, side effects, results and how long they will last?**
8	**Do all patients receive a consultation with the doctor/surgeon/nurse undertaking the cosmetic procedure prior to surgery/ treatment?** Yes ☐ No ☐ If **No**, please provide details:
9	**Are all patients given a 'Patient Guide' detailing clear and accurate information in relation to the treatment, costs and other services?** Yes ☐ No ☐ If **No**, please provide details:
10	**Please provide full details of laser treatments (including the equipment make, model, circumstance of use/conditions treated).**
	Please enclose standard consent form(s).

ADDENDUM 2: MATERNITY/OBSTETRICS

1	**Please state the number of Deliveries per annum:**	
	Including:	
	a) Multiple Births:	
	b) Healthy Neonatals:	
	c) Stillborn Infants:	
	d) Number of infants admitted to the NICU/SCBU:	
	i. From your own Obstetrical Department:	
	ii. Transferred from entities outside the control of the Proposer:	
2	**Is an Obstetrician available in-house twenty four (24) hours per day?**	Yes ☐ No ☐
3	**Is a second Obstetrician on call twenty four (24) hours per day who is able to attend within thirty (30) minutes?**	Yes ☐ No ☐
4	**Is a Paediatrician available in-house twenty four (24) hours per day?**	Yes ☐ No ☐
5	**Is an Anaesthetist available solely to the obstetrical department twenty four (24) hours per day?**	Yes ☐ No ☐
6	**Is a second Anaesthetist on call twenty four (24) hours per day who is able to attend within thirty (30) minutes?**	Yes ☐ No ☐
7	**Can emergency Caesarean sections be performed within thirty (30) minutes, twenty four (24) hours per day?**	Yes ☐ No ☐
8	**Can Midwives attend births without an attending doctor?**	Yes ☐ No ☐
9	**Can outside doctors attend their own patients?**	Yes ☐ No ☐
10	**Please give brief details of the Proposer's policy in respect of mother and foetal monitoring:**	
11	**Do you offer a counselling service for parents following miscarriage, perinatal death or the birth of handicapped children?**	Yes ☐ No ☐

ADDENDUM ADDITIONAL SPACE

Please use this space to record the answers to any questions for which you require additional space, noting the appropriate question number.