VANDEN

# Clinic/non-Hospital Medical Malpractice Proposal Form

**Section 1 - Company Details**

| | | |
|---|---|---|
| 1.1 | Name of Organisation: | |
| | Trading name (if different): | |
| | Contact tel: | Contact email: |
| | Date established: | Web address: |
| | Registration date: | Registration type: |

| 1.2 | **Principal address** | **Registered address (if different)** |
|---|---|---|
| | Line 1: | Line 1: |
| | Line 2: | Line 2: |
| | Line 3: | Line 3: |
| | Town: | Town: |
| | County: | County: |
| | Country: | Country: |
| | Postcode: | Postcode: |

Please fill in blank page at the back of this proposal form for additional locations

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1.3 | Tax status: | ☐ | For profit | ☐ | Not for profit | ☐ | Public | ☐ Government Entity |

1.4 List of professional bodies/associations/regulatory bodies with whom you hold a license /membership

1.5 Have you ever had any disputes/conditions/orders placed on you by a regulatory body following an inspection Yes / No

if "Yes" please provide details:

1.6 **Professional Services**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aesthetic Treatment Clinics | ☐ | Diagnostic Imaging Facilities | ☐ | Hospices | ☐ | Pathology Labs | ☐ |
| Ambulance Services | ☐ | Drug Testing Centres | ☐ | Industrial / Occupational Health | ☐ | Primary Care Clinics | ☐ |
| Assisted living | ☐ | Emergency / Urgent Care Centres | ☐ | IVF/ Assisted Conception | ☐ | Rehabilitation Centres | ☐ |
| Clinical Research Establishments | ☐ | First Aid / Paramedic Group | ☐ | Medical Employment Agencies | ☐ | Residential Care | ☐ |
| Complementary Medical Facilities | ☐ | GP surgery | ☐ | Medical Repatriation / Air Ambulance | ☐ | Specialty Care Clinics | ☐ |
| Dental clinic | ☐ | Home Health Services | ☐ | Outpatient Surgery Centres | ☐ | Walk in centre | ☐ |

Other (please specify)

1.7 **Please provide a full description of the services provided for which cover is sought:**

| | **Section 2 - Exposure Details** | Past Financial Year | Current Financial Year | Next Financial Year |
|---|---|---|---|---|
| 2.1 | **Financial** | | | |
| | Gross revenue | | | |
| | Profit/Loss | | | |
| | Net Cash | | | |
| | Wageroll | | | |
| 2.2 | **Beds** | | | |
| | Admitted | | | |
| | Day-care | | | |
| | Total | | | |
| | % Occupancy | % | % | % |
| | *Below bed sub section to be included in above total* | | | |
| | Psychiatric (non-sectioned) | | | |
| | Psychiatric (sectioned) | | | |
| | Other (please specify) | | | |
| | Other (please specify) | | | |
| 2.3 | **Patient visits** | | | |
| | Admitted patients | | | |
| | Outpatients | | | |
| | A&E | | | |
| | Inpatient surgeries | | | |
| | Outpatient surgeries | | | |
| 2.4 | **Theatres** | | | |

| 2.7 | **Clinical Trials. If "No" move to question 2.8** | | | | | Yes / No | |
|---|---|---|---|---|---|---|---|
| | | Past Financial Year | | Current Financial Year | | Next Financial Year | |
| | | Number of trials | Subject numbers | Number of trials | Subject numbers | Number of trials | Subject numbers |
| | First in man | | | | | | |
| | Phase 1 | | | | | | |
| | Phase 2 | | | | | | |
| | Phase 3 | | | | | | |
| | Phase 4 | | | | | | |
| | Bioequivalence | | | | | | |
| | Do all trial subjects sign an informed consent form? | | | | | Yes / No | |

**Section 3- Medical Staff**

Please indicate full time equivalent and if medical staff have their own medical malpractice cover, "Yes" or "No".

| Doctors | Employed | | Non-employed | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| Anaesthesiology | | | | |
| Chiropractor | | | | |
| Colonoscopy | | | | |
| Dermatology | | | | |
| Diabetes | | | | |
| ENT/Otorhinolaryngology | | | | |
| Gastroenterology | | | | |
| General Practice | | | | |
| Geriatrics | | | | |
| Gynaecology | | | | |
| Haematology | | | | |
| Hospitalist/SHO | | | | |
| Intensive Care Medicine | | | | |
| Neurology | | | | |
| Nuclear Medicine | | | | |
| Occupational Medicine | | | | |
| Oncology | | | | |
| Ophthalmology | | | | |
| Paediatrics | | | | |
| Pathology | | | | |
| Pharmacology | | | | |
| Podiatric Medicine | | | | |
| Psychiatrist | | | | |
| Radiologist | | | | |
| Venereology | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |

| Surgeons | Employed | | Non-employed | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| Abdominal | | | | |
| ENT/Otorhinolaryngology | | | | |
| Gastroenterology | | | | |
| General | | | | |
| Gynaecologic | | | | |
| Maxillofacial | | | | |
| Orthopaedic (non-spinal) | | | | |
| Orthopaedic (spinal) | | | | |
| Paediatric | | | | |
| Plastic cosmetic | | | | |
| Plastic reconstructive | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| **Other Medical Staff** | | | | |
| Acupuncture | | | | |
| Complimentary | | | | |
| Counsellor | | | | |
| Dental | | | | |
| Lab technicians | | | | |
| Nurse Practitioners | | | | |
| Optometrist | | | | |
| Paramedics | | | | |
| Pharmacists | | | | |
| Physiotherapist | | | | |
| Psychologist | | | | |
| Registered Nurses | | | | |
| Other | | | | |
| Other | | | | |

For all surgical procedures please complete the Surgeon's medical malpractice addendum

For all dental procedures please complete the Dentists medical malpractice addendum

For all IVF/assisted conception procedures please complete the IVF/assisted conception medical malpractice addendum

**Section 4 - Risk Management**

| | |
|---|---|
| 1. Do you have a complaints system and nominated complaints manager? | Yes / No |
| 2. Do you have a reliable method for recording and passing on messages? | Yes / No |
| 3. Do you have a system of peer review in place to monitor standards of patient note taking? | Yes / No |
| 4. Do you have a reliable method for making sure that the results of tests and investigations are received and communicated to patients? | Yes / No |
| 5. Do you have a system for reviewing repeat prescriptions | Yes / No |
| 6. Do you have a written procedure for recording/reporting and investigating events with adverse outcomes or the potential for an adverse outcome? | Yes / No |
| 8. Do you have a documented informed consent procedure? | Yes / No |
| 9. Do all staff fully understand the concepts of informed consent? | Yes / No |
| 10. Do you have a policy for managing difficult patients? | Yes / No |
| 11. Are all staff vaccinated against Hepatitis B and is this monitored appropriately? | Yes / No |
| 12. Does the practice have a system to ensure that patients on medication requiring monitoring are identified and treated properly? | Yes / No |
| 13. Do you require that all medical staff are registered and/or licensed with the relevant regulatory body? | Yes / No |
| 14. Do you require that all medical staff are re-credentialed annually? | Yes / No |
| 15. Do you require all employed medical staff to carry their own medical insurance? | Yes / No |
| If "Yes" what minimum limit do you require? | |
| 16. Do you require all non-employed medical staff to carry their own medical insurance? | Yes / No |
| If "Yes" what minimum limit do you require? | |
| 17. Do you require that all medical staff provide evidence of insurance cover on an annual basis? | Yes / No |
| 18. How long are medical records kept from the date of treatment? | |
| 19. When was the last CQC (or equivalent) inspection: | |
| What was the outcome of this inspection<br><br>If "Improvements Required" or "Enforcement Action" recommended please supply details | |

**Section 5 - Previous Insurance Details and Claims History**

| | |
|---|---|
| 1. Have you had medical malpractice insurance before | Yes / No |

2. Please give full details of your previous medical indemnity cover. Provide 10 years history or since trading if later:

| Insurer/MDO | (dd/mm/yyyy) | To (dd/mm/yyyy) | Limit of Indemnity | Excess | Premium |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | |
|---|---|
| 3. Have there been any gaps in your medical indemnity cover during the last ten years? If you have answered "Yes" please confirm the dates and the reason for any gap below. | Yes / No |
| 4. Are you aware of any complaints or claims that have ever been brought and/or threatened against you, and/or any circumstances which could lead to a complaint and/or claim against you?<br>If you have answered "Yes" please provide full details below or use the Claims History template addendum. | Yes / No |
| 5. Please confirm all of the above claims, complaints, circumstances been made and accepted by your previous medical indemnity providers? | Yes / No |
| 6. Has any medical indemnity insurer/Medical Defence Organisation ever: | |
| Declined to insure you? | Yes / No |
| Imposed special conditions | Yes / No |
| Declined to renew/cancelled your insurance? | Yes / No |

**Section 6 - Indemnity Requirements**

| | |
|---|---|
| 1. Please advise the date that cover is first required: | |
| 2. Was previous cover on a claims made basis? | Yes / No |
| If you have answered "Yes" what retroactive date is required? | |
| 3. Please indicate the limit of indemnity now required? | |

**Section 7 - Declaration**

I/We declare that after full investigation I/we are unaware of any claims and/or circumstances that could give rise to a claim, other than those already declared in the proposal

I/We declare that the statements and particulars contained in the proposal are true and that I/we have not mis-stated or suppressed any material facts.

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

I/We undertake to inform Insurers of any material alteration to these facts occurring before completion of the contract of insurance. However, the duty to disclose material facts continues after the completion of the proposal form and throughout any period of insurance (and any extension thereto), upon which this proposal form was used as the basis of the contract of insurance.

Signing this proposal form does not bind the proposer to complete this insurance.

Signature of authorised Individual/Partner/Principal/Director: _____

Date:_____

Print Name:_____

Position:_____

Please use this page for any additional information requested in the proposal form or that Insurers might otherwise need to be made aware of.