



Broker at **LLOYD'S**

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	<input type="checkbox"/>	Diagnostic Imaging Facilities	<input type="checkbox"/>	Hospices	<input type="checkbox"/>	Pathology Labs	<input type="checkbox"/>
Ambulance Services	<input type="checkbox"/>	Drug Testing Centres	<input type="checkbox"/>	Industrial / Occupational Health	<input type="checkbox"/>	Primary Care Clinics	<input type="checkbox"/>
Assisted living	<input type="checkbox"/>	Emergency / Urgent Care Centres	<input type="checkbox"/>	IVF/ Assisted Conception	<input type="checkbox"/>	Rehabilitation Centres	<input type="checkbox"/>
Clinical Research Establishments	<input type="checkbox"/>	First Aid / Paramedic Group	<input type="checkbox"/>	Medical Employment Agencies	<input type="checkbox"/>	Residential Care	<input type="checkbox"/>
Complementary Medical Facilities	<input type="checkbox"/>	GP surgery	<input type="checkbox"/>	Medical Repatriation / Air Ambulance	<input type="checkbox"/>	Specialty Care Clinics	<input type="checkbox"/>
Dental clinic	<input type="checkbox"/>	Home Health Services	<input type="checkbox"/>	Outpatient Surgery Centres	<input type="checkbox"/>	Walk in centre	<input type="checkbox"/>
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	%	%	%
	<i>Below bed sub section to be included in above total</i>			
	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			

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		Surgeons	Employed		Non-employed	
	Yes	No	Yes	No		Yes	No	Yes	No
Anaesthesiology					Abdominal				
Chiropractor					ENT/Otorhinolaryngology				
Colonoscopy					Gastroenterology				
Dermatology					General				
Diabetes					Gynaecologic				
ENT/Otorhinolaryngology					Maxillofacial				
Gastroenterology					Orthopaedic (non-spinal)				
General Practice					Orthopaedic (spinal)				
Geriatrics					Paediatric				
Gynaecology					Plastic cosmetic				
Haematology					Plastic reconstructive				
Hospitalist/SHO					Other				
Intensive Care Medicine					Other				
Neurology					Other				
Nuclear Medicine					Other				
Occupational Medicine					Other Medical Staff				
Oncology					Acupuncture				
Ophthalmology					Complimentary				
Paediatrics					Counsellor				
Pathology					Dental				
Pharmacology					Lab technicians				
Podiatric Medicine					Nurse Practitioners				
Psychiatrist					Optometrist				
Radiologist					Paramedics				
Venereology					Pharmacists				
Other					Physiotherapist				
Other					Psychologist				
Other					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?	

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	From (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? 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 declare that I/we have made a fair presentation of the risk, by disclosing all material matters which I/we know or ought to know or, failing that, by giving the Insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries in order to reveal material circumstances.

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).

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

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

Date: _____

Print Name: _____

Position: _____

