MedPro
part of the Berkshire Hathaway family

Healthcare Liability Insurance

PROPOSAL FORM

Hospitals and Inpatient Facilities

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Instructions and Important Notices

This Proposal Form can be completed electronically or by hand and must be signed and dated by an authorized representative of the Insured. All hand-written notes must be clearly legible, and all questions should be answered fully, stating “NIL” or “NONE” as applicable. Incomplete answers may delay quotation.

Please attach all supporting documents and include as much detail as possible, using the supplemental information section and additional sheets as required.

THIS PROPOSAL FORM IS FOR A CLAIMS MADE AND REPORTED POLICY.

Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date which are reported to the Insurer during the policy period or any applicable extended reporting period. Please read and review the policy carefully.

IT IS THE DUTY OF THE PROPOSER TO DISCLOSE ALL MATERIAL FACTS TO THE INSURER.

The Insurer will rely upon the material facts and information supplied in this Proposal Form. Upon acceptance of the Insurer’s terms and conditions and payment of the premium, all information provided by the Proposer together with the guidance notes will be deemed to be incorporated in the contract between the Insurer and the Insured. Please ensure you have signed and dated the declaration at the end of this Proposal Form.

1. General Information

A. Name of Organisation

B. Trading Name (if different)

C. Date Established

D. Website Address

E. Registered Address

F. Trading Address

G. Contact Telephone

H. Contact Email Address

I. Details of ultimate owner or holding company

J. Type of Organisation (tick to all that apply)

- ☐ HEALTH SYSTEM
- ☐ CHILDREN’S HOSPITAL
- ☐ COMMUNITY HOSPITAL
- ☐ GENERAL HOSPITAL
- ☐ SURGICAL HOSPITAL
- ☐ REHABILITATION HOSPITAL
- ☐ TEACHING HOSPITAL
- ☐ MATERNITY HOSPITAL
- ☐ PSYCHIATRIC HOSPITAL

OTHER (PLEASE DESCRIBE):

K. Ownership Structure (tick to all that apply)

- ☐ FOR-PROFIT CORPORATE
- ☐ NOT FOR-PROFIT CORPORATE
- ☐ GOVERNMENT ENTITY
- ☐ PARTNERSHIP

2. Licensing and Regulation

A. Are you currently in possession of the relevant licences/registrations from the applicable regulatory bodies as required by law, for all of the services you currently offer: ☐ YES ☐ NO

IF NO, PLEASE DESCRIBE

B. Please list the associations, professional bodies and regulatory organisations with whom you hold a licence/membership or are registered.

C Have you ever had a dispute with any regulatory body regarding an Inspection Report? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS

D. Do you provide management services to other institutions or vice versa? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS

E. Have you sold or discontinued any operations or services including assets and / or liabilities in the past 5 years, or do you plan to do so in the next year? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS

3. Financial Information

A. Please provide the following information for the past, current and future financial years:

CURRENCY If other:

	PAST FINANCIAL YEAR	CURRENT FINANCIAL YEAR	NEXT YEAR (ESTIMATE)
GROSS REVENUE			
OPERATING PROFIT / LOSS			
NET CASH			

B. Please provide your funding split from the following sources (%):

	GOVERNMENT / PUBLIC FUNDING		NATIONAL INSURANCE
	PRIVATE INSURANCE		SELF-PAY

4. Professional Healthcare Services

A. Please indicate the services you provide:

- ☐ AMBULANCE*
- ☐ ANAESTHESIA SERVICES*
- ☐ ASSISTED CONCEPTION (IVF)**
- ☐ BARIATRIC SURGERY**
- ☐ BLOOD BANK*
- ☐ BURN UNIT
- ☐ CARDIOLOGY
- ☐ CATHETERISATION LAB
- ☐ CLINICAL TRIALS **
- ☐ CORONARY HEART UNIT (CCU)
- ☐ CORRECTIONAL / PRISON HEALTH
- ☐ DAY CARE
- ☐ DENTAL
- ☐ DIABETES CARE
- ☐ DIALYSIS
- ☐ EMERGENCY SERVICES*
- ☐ ENDOCRINOLOGY
- ☐ FAMILY PRACTICE
- ☐ GASTROENTEROLOGY
- ☐ GENETIC TESTING
- ☐ GYNAECOLOGY
- ☐ HOME HEALTH
- ☐ INFECTIOUS DISEASES
- ☐ INTENSIVE CARE (ICU)
- ☐ INTERNAL MEDICINE
- ☐ LAB SERVICES*
- ☐ LONG TERM CARE
- ☐ MEDICAL TOURISM**
- ☐ NEONATAL ICU
- ☐ NEUROSURGERY
- ☐ OBSTETRICS*
- ☐ ONCOLOGY
- ☐ OPHTHALMOLOGY
- ☐ ORTHOPAEDICS
- ☐ PHARMACY*
- ☐ PHYSICAL THERAPY
- ☐ PLASTIC / COSMETIC SURGERY
- ☐ PSYCHIATRY / BEHAVIOURAL HEALTH**
- ☐ RADIATION THERAPY
- ☐ RADIOLOGY*
- ☐ REHABILITATION
- ☐ RESEARCH
- ☐ SPORTS MEDICINE*
- ☐ SURGERY – INPATIENT*
- ☐ SURGERY – OUTPATIENT
- ☐ TELEMEDICINE**
- ☐ TRANSPLANT*
- ☐ UROLOGY

* please complete service line specific sections below

** please complete relevant proposal form addendum

B. Ambulance

I) Do you operate any ambulances? ☐ YES ☐ NO

IF YES, WHAT IS THE NUMBER OF RUNS ANNUALLY? _____ EMERGENCY _____ NON-EMERGENCY

II) Are the ambulances used for: ☐ PATIENT TRANSFERS ☐ FIRST RESPONSE ☐ BOTH

III) Number of ambulances owned or operated: _____ ROAD _____ AIR

IV) Please list the countries in which you operate ambulance services:

C. Anesthesia Services

I) Is there 24/7 rota for the availability of an anaesthetist? ☐ YES ☐ NO

II) Do you use nurse anaesthetists? ☐ YES ☐ NO

IF YES, DO THEY CARRY SEPARATE PROFESSIONAL INDEMNITY COVER? ☐ YES ☐ NO

IF YES, Please state your approximate average ratio of anaesthetists to nurse anaesthetists. _____

D. Blood Bank Services

I) Do you own / operate a blood bank other than receiving blood from an outside vendor or autologous transfers? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS OF SERVICES PROVIDED:

II) Please list any vendors that supply you with blood or blood products:

III) Is any blood or blood product bought or obtained from outside the country in which you operate? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY WHERE THE PRODUCTS ARE OBTAINED:

IV) Are all blood or blood product units tested before use? ☐ YES ☐ NO

V) Do you outsource any of your blood tests? ☐ YES ☐ NO

IF YES, DO THE OUTSOURCING COMPANIES EACH CARRY SUITABLE PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

E. Emergency Services

I) Do you provide 24/7 attending emergency medicine physician or resident medical officer cover? ☐ YES ☐ NO

II) Please specify your average wait time (in minutes):

III) Do any of the emergency department staff routinely work more than a 12-hour shift? ☐ YES ☐ NO

IV) Are evidence-based clinical protocols in place for:

☐ **CHEST PAIN** ☐ **ABDOMINAL PAIN** ☐ **FEVER IN CHILDREN** ☐ **HEADACHE**

V) Do you have constant availability of emergency equipment, is this regularly checked and are staff trained in use? ☐ YES ☐ NO

VI) Is there a written procedure for transferring all emergency patients to an appropriate alternative facility if necessary? ☐ YES ☐ NO

VII) Are written agreements in place with other facilities governing the transfer of patients? ☐ YES ☐ NO

F. Laboratory Services

I) Approximately how many of each of the following types of lab services are performed each year:

	LAST 12 MONTHS	NEXT 12 MONTHS (ESTIMATE)
PATHOLOGY		
BLOOD BANKING		
PRE-NATAL GENETIC TESTING		
OTHER (PLEASE SPECIFY):		
DESCRIPTION OF OTHER		

II) Do you provide laboratory services to other healthcare organisations? ☐ YES ☐ NO

III) What percentage of your work is outsourced to other labs?

IV) Do you have an electronic system for all specimens processed? ☐ YES ☐ NO

V) Do you have a written procedure for follow up if a provider is unable to receive test result information? ☐ YES ☐ NO

G. Obstetrical Services

I) Are you a regional referral centre for high-risk pregnancies or newborns? YES NO

If No, is there a written procedure for transferring all high risk mothers and/or babies that you are not qualified to treat? YES NO

II) Do you provide ongoing treatment for high-risk pregnancies or newborns? YES NO

III) Please complete the following table with the number of deliveries per annum:

	LAST 12 MONTHS	NEXT 12 MONTHS (ESTIMATE)
VAGINAL		
CAESAREAN		
VBAC		

IV) Is an attending obstetrician required to review foetal monitor strips periodically during labour or delivery? YES NO

V) Is continuous electronic foetal monitoring performed on all patients in active labour? YES NO

VI) Is an attending obstetrician required to approve the use of oxytocic drugs during labour? YES NO

VII) Can midwifes perform deliveries other than uncomplicated normal deliveries without an obstetrician being present? YES NO

VIII) Is an obstetrician available in-house 24 hours per day? YES NO

IX) Can caesarean sections be performed within 30 minutes 24 hours per day? YES NO

X) Are any deliveries performed outside the hospital? YES NO

IF YES, PLEASE PROVIDE DETAILS:

H. Pharmaceutical Services

I) Does a full time registered pharmacist direct the pharmacy? YES NO

II) Do you provide pharmacy services to other organisations? YES NO

III) Does the pharmacy use a bar coding system for dispensing medicine? YES NO

IV) Is the pharmacy staffed 24-hours a day? YES NO

V) Are you in compliance with all applicable regulatory laws governing the manufacture, control dispensing and distribution of prescription drugs? YES NO

I. Radiology Services

I) Is a radiologist on-site 24 hours per day? YES NO

II) Please indicate the types of reads provided:

XRAY CT / MRI / PET / ULTRASOUND MAMMOGRAPHY RADIATION ONCOLOGY / THERAPY

III) Is a physician present during the injection of contrast media? YES NO

IV) Do you use teleradiology for the interpretation of reads? YES NO

IF YES, WHAT % OF TOTAL SERVICES DOES THIS REPRESENT?

V) Do you provide teleradiology services to other healthcare organisations? YES NO

VI) Do you have written protocols for handling allergic reactions including cardiac or respiratory arrest? YES NO

J. Sports Medicine

I) Do you provide medical services for any professional sportspeople or teams? YES NO

IF YES, PLEASE DESCRIBE:

K. Surgical Services

I) Are you a regional referral centre for any surgical services? YES NO

II) Can a House officer or Residents perform surgery without an attending surgeon being present? YES NO

III) Do you use any of the following (tick all that apply)

SURGICAL CHECKLISTS **SIMULATION TRAINING** **MANUAL SPONGE COUNT**

IV) Do you undertake any of the following surgical procedures?

BARIATRIC	**TYPE:**
COSMETIC	**TYPE:**
ORGAN TRANSPLANTS	**TYPE:**
GENDER REASSIGNMENT	**TYPE:**
NEUROSURGICAL	**TYPE:**

L. Telemedicine

I) Please describe the nature and types of telemedicine services you offer:

II) What % of your total annual patient encounters are conducted digitally?

IF HIGHER THAN 20%, PLEASE COMPLETE THE MEDPRO TELEMEDICINE ADDENDUM.

III) Do you have written policies and procedures in place for identifying and treating emergency situations and referral criteria for patients who need a higher level of care? YES NO

IV) Do you have written policies in place describing the process to coordinate care with a patient's primary care provider? YES NO

V) Please list the countries in which telemedicine is offered:

VI) Are medical staff undertaking telemedicine services licensed to provide these services in the patients' country of domicile YES NO

VII) Do you provide second opinion services? YES NO

5. Exposures

A. Please complete the following tables as completely as possible with the most up to date information available.

BEDS	THIS YEAR LICENSED	THIS YEAR OCCUPIED	PRIOR YEAR 1 OCCUPIED	PRIOR YEAR 2 OCCUPIED	PRIOR YEAR 3 OCCUPIED	PRIOR YEAR 4 OCCUPIED
Medical / Surgical						
Bassinets & Cribs						
Maternity / Obstetric						
Intensive Care (ICU)						
Neonatal Intensive Care (NICU)						
Psychiatric						
Chemical Dependency / Rehabilitation						
Long Term Care (Hospice)						
Long Term Acute Care (LTAC)						
Other (please specify):						

ADMISSIONS/TRANSFERS	THIS YEAR	PRIOR YEAR 1	PRIOR YEAR 2	PRIOR YEAR 3	PRIOR YEAR 4
Inpatient admissions					
Transfers in					
Transfers out					

PROCEDURES	THIS YEAR	PRIOR YEAR 1	PRIOR YEAR 2	PRIOR YEAR 3	PRIOR YEAR 4
Inpatient Surgeries					
Births					
Outpatient Surgeries					

OUTPATIENT VISITS	THIS YEAR	PRIOR YEAR 1	PRIOR YEAR 2	PRIOR YEAR 3	PRIOR YEAR 4
Emergency					
Outpatient Clinic					
Radiological					
Home Health					
Other (please specify):					

B. Please estimate the percentage split of total patients as follows:

DOMESTIC FOREIGN USA

IF FOREIGN, PLEASE SPECIFY COUNTRIES:

C Do you anticipate any material changes to your activities in the forthcoming 12 months? YES NO

IF 'YES', PLEASE GIVE DETAILS BELOW

6. Medical Staff

A. Please provide details of all your medical staff for the forthcoming period of insurance, on a Full Time Equivalent (FTE) basis. Please split the FTE for medical staff working across multiple specialties as accurately as possible.

Doctors

SPECIALTY	EMPLOYED FTE	NON-EMPLOYED FTE	SPECIALTY	EMPLOYED FTE	NON-EMPLOYED FTE
Anaesthesiology			Nephrology		
Cardiology			Nuclear Medicine		
Colonoscopy			Occupational Medicine		
Dermatology			Oncology		
Diabetes			Ophthalmology		
Emergency Medicine			Paediatrics		
Endocrinology			Pathology		
ENT			Perinatology		
General Practice			Podiatry		
Gastroenterology			Psychiatry		
Geriatrics			Radiology		
Gynaecology			Rhinology		
Haemotology			Sports Medicine		
Infectious Disease			Urology		
Intensive Care Medicine			Other (please specify):		
Neonatology					

Surgeons

SPECIALTY	EMPLOYED FTE	NON-EMPLOYED FTE	SPECIALTY	EMPLOYED FTE	NON-EMPLOYED FTE
Abdominal			Orthopaedic excl. Spine		
Cardiac			Orthopaedic incl. Spine		
Colon and rectal			Perinatology		
Emergency			Plastic - elective		
ENT			Plastic - reconstructive		
Gastroenterology			Thoracic		
General			Transplant		
Gynaecology			Urology		
Hand			Vascular		
Head & Neck			Other (please specify):		
Maxillofacial					
Neonatology					
Obstetrics					

Healthcare Professionals

SPECIALTY	EMPLOYED FTE	NON-EMPLOYED FTE	SPECIALTY	EMPLOYED FTE	NON-EMPLOYED FTE
Acupuncture			Nurse Practitioner		
Chiropractor			Paramedic		
Complementary Therapist			Physician Assistant		
Dentist			Physiotherapist		
Dental Hygienist			Pharmacist		
Dental Nurse			Registered Nurse		
Healthcare Assistant			Other (please specify):		
Lab Technician					
Midwife					

B. Have the numbers of medical staff changed significantly over the past 5 years? YES NO

IF YES, PLEASE PROVIDE DETAILS:

C. Do you require that all professionally qualified staff:

I) Are registered with or licensed by the relevant government regulatory body or licensing and registration body? YES NO

II) Are adequately trained and competent for their role? YES NO

III) Are adequately supervised under the appropriate management? YES NO

IV) Are re-credentialed on at least an annual basis? YES NO

IF 'NO', HOW OFTEN ARE MEDICAL STAFF MEMBERS RE-CREDENTIALED?

D. Have any professionally qualified staff ever been subject to disciplinary proceedings for misconduct in professional matters? YES NO

IF YES PLEASE ATTACH DETAILS.

E. Do you require primary coverage for non-employed medical staff? YES NO

F Do you require that all non-employed medical staff:

I) Carry their own medical professional liability insurance or maintain Indemnity via a Medical Defence Organisation? YES NO

IF YES PLEASE SPECIFY LIMITS REQUIRED:

II) Provide evidence of this coverage on an annual basis, as part of your practitioner credentialing process? YES NO

G. Do you use agency staffing? YES NO

IF SO, WHAT % OF YOUR TOTAL STAFF IS USUALLY REPRESENTED BY AGENCY STAFF?

H. Are Advanced Clinical Practitioners authorised to prescribe medication to patients? YES NO

I. What ratio of physician supervision is required for Advanced Clinical Practitioners?

7. Risk Management and Quality Assurance

A. Clinical Risk Management

I) Staff member responsible for clinical risk management:

NAME	POSITION

II) Do you have a documented clinical risk management strategy and policy? YES NO

III) Do you have a Clinical Governance and/or Clinical Risk Management Committee? YES NO

IV) Do you provide a clinical risk management training programme for all staff? YES NO

V) Do you provide facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that cross infection methods are employed? YES NO

VI) Do you comply with the current guidelines for the safe collection and disposal of any clinical / medical waste products? YES NO

VII) In what format are Medical Records stored? Written Electronic Both

VIII) How long are medical records retained from the date of treatment?

IX) Do you have an informed consent policy in line with best practice within your industry? YES NO

X) Do you have a written procedure for the reporting and handling of sexual misconduct / abuse allegations? YES NO

B. Quality Assurance

I) Do you have a formal programme for clinical quality assurance / improvement? YES NO

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

III) Please provide details of accreditations you currently hold with national or international quality, risk management or patient safety accreditation bodies.

C. Privacy / Network Security

I) Do you protect sensitive information in compliance with relevant privacy legislation? YES NO

II) Do you enforce a network security policy that must be followed by all employees, contractors or any other person with access to your network? YES NO

III) Do you test your network security at least annually to ensure the effectiveness of technical controls as well as procedures for responding to network security incidents? YES NO

IV) Please list any external cyber security certifications or quality standards which you adhere to:

8. Incidents and Claims

A. Do you have a written procedure for the reporting of incidents and adverse events? ☐ YES ☐ NO

B. Do you have a written procedure for the investigation and follow up of adverse events? ☐ YES ☐ NO

IF NO, TO EITHER OF THE ABOVE, PLEASE PROVIDE DETAILS ON HOW INCIDENTS AND ADVERSE EVENTS ARE REPORTED AND INVESTIGATED:

C. Do you operate an “open disclosure” policy? ☐ YES ☐ NO

D. Do you have a complaints manager for the handling of patient complaints? ☐ YES ☐ NO

E. Do you have a written procedure for the handling of patient complaints? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS ON HOW PATIENT COMPLAINTS ARE HANDLED AT YOUR ORGANISATION:

F. Do you currently manage claims in-house? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS OF YOUR APPROACH TO RESERVING:

G. Please provide details of any third party administrator, loss adjuster or legal firm who you currently use in the handling of your claims:

H. During the last 10 years has any claim been made, defended or settled, or has any malpractice or negligence been alleged against you? ☐ YES ☐ NO

I. Are there any circumstances which may result in a claim against you or any prior corporate practice, predecessors in business or any present or former partner, principal or Director or Professional Practitioner? ☐ YES ☐ NO

J. Has any Partner, Principal or Director or member of staff ever been subject to disciplinary proceedings for professional misconduct? ☐ YES ☐ NO

IF YOU HAVE ANSWERED ’YES’ TO ANY OF THE ABOVE, PLEASE LIST ALL CIRCUMSTANCES/ CLAIMS OVER THE LAST 10 YEARS IN A SEPARATE LOSS RUN IN EXCEL FORMAT.

9. Coverage Requirements

A. Please advise the first day that cover is required:

B. Please provide full details of your healthcare professional liability cover for the past 3 years:

PERIOD OF COVER	INSURER	LIMIT OF INDEMNITY	EXCESS	PREMIUM

C. Has prior cover been on a claims made basis? ☐ YES ☐ NO

IF YES, WHAT IS THE CURRENT RETROACTIVE DATE?

D. Please provide details of coverage requested:

LIMIT OF INDEMNITY	**OPTION 1**		**OPTION 2**	
EXCESS / DEDUCTIBLE	**OPTION 1**		**OPTION 2**	

E. Has any proposal for similar insurance been made on behalf of the proposer's business, any predecessor of the business, or any Partner, Principal, Director ever been declined or has such insurance ever been cancelled, had renewal refused or had any special terms imposed (other than general market increases)? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

F. Please provide details of the territories/legal jurisdiction(s) in which coverage is required:

G. Describe any statutory, legal or administrative provision which might serve to limit or otherwise affect the institution's liability of loss exposure (e.g. statutory caps on damages, tort reform etc.)

H. Please outline any further information that you believe may affect Underwriters' consideration of the risk:

10. Declaration and Additional Information

A. Please attach as much of the following information to this application form as possible to enable underwriters to fully assess the risk:

I) SCHEDULE OF NAMED INSUREDS
II) SCHEDULE OF EMPLOYED PHYSICIANS
III) LATEST FINANCIAL STATEMENTS
IV) ORGANISATION CHART
V) 10 YEAR LOSS RUNS IN EXCEL FORMAT
VI) ACTUARIAL REPORT
VII) LATEST ACCREDITATION/LICENSING REPORT
VIII) ADDITIONAL ADDENDUMS AS REQUIRED

B. Declaration and signature

I/We declare that the statements and particulars contained in the proposal are true and that I/we have not misstated 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.

C. SIGNATURE OF AUTHORISED INDIVIDUAL / PARTNER / PRINCIPAL / DIRECTOR

SIGNATURE

DATE

POSITION

PRINT NAME

PHONE

EMAIL

11. Supplementary Information

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