MedPro
part of the Berkshire Hathaway family

Healthcare Liability Insurance

PROPOSAL FORM

Outpatient Facilities and Healthcare Service Providers

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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

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 Please Choose 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 describe in full the professional healthcare services you provide for which coverage is sought:

B. Do you have any inpatient facilities? YES NO

IF YES, PLEASE COMPLETE THE MEDPRO HOSPITALS AND INPATIENT FACILITIES PROPOSAL FORM

C. Please state the number of procedures performed by you for the current and prior annual periods (please specify types of procedures performed where possible)

PROCEDURES

SURGICAL (PLEASE SPECIFY):	THIS YEAR	PRIOR YEAR 1	PRIOR YEAR 2	PRIOR YEAR 3	PRIOR YEAR 4

NON SURGICAL (PLEASE SPECIFY):	THIS YEAR	PRIOR YEAR 1	PRIOR YEAR 2	PRIOR YEAR 3	PRIOR YEAR 4

OUTPATIENT VISITS:	THIS YEAR	PRIOR YEAR 1	PRIOR YEAR 2	PRIOR YEAR 3	PRIOR YEAR 4
Emergency / Urgent Care					
Radiological Visits					
Clinic Visits					
Lab / Pathology					
Other (please specify):					

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

DOMESTIC FOREIGN USA

IF FOREIGN, PLEASE SPECIFY COUNTRIES:

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

IF 'YES', PLEASE PROVIDE DETAILS

5. Medical Staff

A. Please advise Full Time Equivalent (FTE) medical staff working on your behalf during the forthcoming period of insurance:

Doctors	EMPLOYED FTE	NON-EMPLOYED FTE
General Practice		
Specialist Practice (Please specify):		

Healthcare Professionals	EMPLOYED FTE	NON-EMPLOYED FTE
EMT / Paramedic		
Midwife		
Registered Nurse		
Nurse Practitioner		
Technician		
Other (please specify):		

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

SUPPLEMENTARY INFORMATION

6. 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:

7. 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.

8. 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:

9. Declaration

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.

SIGNATURE OF AUTHORISED INDIVIDUAL / PARTNER / PRINCIPAL / DIRECTOR

SIGNATURE

DATE

POSITION

PRINT NAME

PHONE

EMAIL

10. Supplementary Information

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