Beazley | Healthcare

proposal form

Instructions

This Proposal form and all materials submitted shall be held in confidence.

All questions must be fully answered and all requested information and/or required attachments submitted to enable a quotation or indication to be given. However, the completion and submission of this form does not bind the applicant or underwriters to enter into any contract of insurance.

If a question does not apply, please write 'N/A'. If the answer is none, please state 'none' or '0'. If more space is needed, please use the supplementary pages at the back of this form. Please provide the currencies for any financial information. This Proposal form and any supplementary pages must be completed, signed and dated by an appropriate and fully authorised officer or principal of the business.

It is your duty to make a fair representation of the risk to the Underwriters in accordance with Section 3 of the Insurance Act 2015 and disclose to underwriters all circumstances and representations material to the proposed insurance. For a summary, please refer to the LMA9117 at the back of this Proposal Form and Section 3 of the Insurance Act 2015 for a full explanation of the Duty of Fair Representation. A circumstance or representation is material if it would influence the judgement of a prudent insurer in determining whether to take the risk and, if so, on what terms.

All of the coverages for which this Proposal form is being submitted are provided on a claims-made basis only. If there are questions concerning any coverage, please contact your insurance agent or broker.

Section 1 – General Information

a) Name of Organisation

_____

b) Trading Name (if different from the above)

_____

c) Principal Trading Address

_____

_____

d) Registered Address (if different from the above)

_____

_____

e) Telephone Number

_____

f) Contact Email Address

_____

g) Website Address

_____

h) Date Established

_____

i) Nature of Services

_____

_____

j) In which countries does the applicant do business?

_____

k) Please describe any management services that the applicant provides for others

_____

_____

l) Applicant Characteristics

For-Profit ☐ Not-For-Profit ☐ Governmental Entity ☐ Sole Trader ☐

Partnership ☐ Franchise ☐ Corporation ☐ Professional Association ☐

If other, please provide details: _____

m) Additional Insured – Please provide the names and descriptions of all legal entities that the applicant intends to cover

Insured Name	Nature of Services	% of ownership	Date Acquired	Retroactive Date	% of Financial Interest
			__/__/____	__/__/____	
			__/__/____	__/__/____	
			__/__/____	__/__/____	

n) Please list any other business(es), owned by the applicant, but not shown in this proposal form, for which coverage is not sought under this policy

_____

_____

o) **Does the applicant plan to carry out any of the activities listed below within the next 12 months?** ***(if yes, please provide further details on the supplementary pages provided)***

i)	Obtain another operation or entity	Yes ☐	No ☐
ii)	Increase the number of employees	Yes ☐	No ☐
iii)	Expand the number of locations	Yes ☐	No ☐
iv)	Eliminate / add current services	Yes ☐	No ☐
v)	Operate in other countries	Yes ☐	No ☐

p) **Has the applicant acquired, sold or discontinued any operations in the past five years?** ***(if yes, please provide further details on the supplementary pages provided)***

Yes ☐ No ☐

q) **Where does the applicant provide services for the client? (The total must equal 100%)**

Applicant's Location	%	**Mobile Facility**	%	**Patients Home**	%
School	%	**Care Home Facility**	%	**Prison**	%
Hospital	%	**Other**	%		

If other, please provide details: _____

r) **Please provide details of any organisational accreditation, certification, licences and/or registration**

i) Is the organisation accredited? ***(If yes, by whom?)*** _____	Yes ☐	No ☐	Expiry date __ / __ / ____
ii) Is the organisation certified? ***(If yes, by whom?)*** _____	Yes ☐	No ☐	Expiry date __ / __ / ____
iii) Is the organisation licensed? ***(If yes, by whom?)*** _____	Yes ☐	No ☐	Expiry date __ / __ / ____
iv) Is the organisation registered? ***(If yes, by whom?)*** _____	Yes ☐	No ☐	Expiry date __ / __ / ____
v) Has any of the above ever been revoked? ***(If yes, by whom?)*** _____	Yes ☐	No ☐	Expiry date __ / __ / ____

s) **Please indicate the gross revenue for the applicant's facility(ies)**

	2017 (estimate)	**2016**	**2015**	**2014**	**2013**
Gross Revenue					

Section 2 – Professional Services and Exposure Information

a) Number of licenced beds – please complete the following table

Inpatient beds	2017 (estimate)	2016	2015	2014	2016 annual occupancy
Acute Care					
Paediatric					
Bassinet					
ICU					
NICU					
Obstetric					
Alcohol / Drug					
Psychiatric					
Rehabilitation					
Skilled Nursing					
Long Term Care					

b) Number of procedures / patient visits – please complete the following table

	Number of procedures / patient visits						
Types of procedures / patient visits	2017 (estimate)	2016	2015	2014	Average length of stay	% of patients under 18 years of age	% of patients from the USA
In patient surgery							
Outpatient surgery							
Outpatient Visits							
Lab & Pathology							
Accident & Emergency							
Home Health Visits							

c) Obstetrics / Gynaecology – please complete the following table

	Total number of births	% of Vaginal births	% of C-Sections	% of VBAC births
Last year (actual)				
Next year (estimate)				

i)	**Is this a referral centre for high-risks births, mothers or infants?**	Yes ☐ No ☐
ii)	**Is an obstetrician available on-site 24/7?**	Yes ☐ No ☐
iii)	**Is there an obstetrician on call 24/7 who can attend within 30 minutes?**	Yes ☐ No ☐
iv)	**Is there a neonatologist available on-site 24/7?**	Yes ☐ No ☐
v)	**Is there a neonatologist on call 24/7 who can attend within 30 minutes?**	Yes ☐ No ☐

d) Does the applicant participate in Clinical Research Trials?

Yes ☐ No ☐

If yes, please provide further details outlining the following on the supplementary pages provided

i) Number of trials
ii) Number of participants
iii) Location of trials performed
iv) Do you receive full indemnity from your principals?
v) Are consent forms signed prior to participation in the trial?

e) Does the applicant provide Bariatric Surgery?

Yes ☐ No ☐

If yes, please provide further details outlining the following on the supplementary pages provided

i) Number of weight loss surgeries per year
ii) Type of weight loss surgery
iii) Do you offer weight loss surgery to patients under the age of 18?
iv) Do you require informed consent prior to any surgery?
v) What checks do you use to exclude patients

f) Does the applicant provide Telemedicine?

Yes ☐ No ☐

If yes, please provide further details outlining the following on the supplementary pages provided

i) Number of encounters per year
ii) Primary (doctor to patient) or Secondary (doctor to doctor)
iii) Countries telemedicine is provided
iv) Do you request indemnity from the institution you are providing secondary telemedicine services to?
v) Are clinical protocols followed when providing telemedicine?

g) Does the applicant provide Pharmacy Services?

Yes ☐ No ☐

If yes, please provide further details outlining the following on the supplementary pages provided

i) Are these services provided to other organisations?
ii) Do you have written procedures in place for safety and risk management?
iii) Do you use electronic bar-coding?
iv) Are you compliant with all relevant regulations?

Section 3 – Medical Professionals Information

a) Pease complete the following table using Full Time Equivalents (FTEs) for all Healthcare Professionals at your facility (excluding Doctors and Surgeons)

Healthcare Professionals	Employed		Non-Employed		Healthcare Professionals	Employed		Non-Employed	
Cover required?	**Yes**	**No**	**Yes**	**No**	**Cover required?**	**Yes**	**No**	**Yes**	**No**
Acupuncturists					Link Nurses				
Advanced Nurse Practitioners					Minor Conditions Nurses				
Allied Healthcare Professionals					Nurses (Other)				
Audit Nurses					Nurse Advisors				
Call Handlers					Nurse Midwives				
Clinical Shift Managers					Nurse practitioners				
Clinical Trainees					Paramedics				
Complementary Medicine Doctor					Pharmacists				
Dental Nurses					Physician Assistants				
District nurses					Physiotherapists				
Emergency Clinical Physicians					Prison Nurses				
Health Care Assistants					Registered Nurses				
Lab Technicians					Students				
					Other				

b) Please complete the following table using Full Time Equivalents (FTEs) for all Medical Practitioners at your facility

Doctors and Surgeons / specialty	Employed		Non-Employed		Doctors and Surgeons / specialty	Employed		Non-Employed	
Cover required?	**Yes**	**No**	**Yes**	**No**	**Cover required?**	**Yes**	**No**	**Yes**	**No**
Abdominal					Nephrology				
Anaesthesiology					Neurology				
Bariatric					Nuclear Medicine				
Cardiac					Obstetrics				
Colon and Rectal					Occupational Medicine				
Colonoscopy					Oncology				
Cosmetic Surgery					Ophthalmology				
Cytopathology					Optometrists				
Dentistry					Oral / Maxillofacial				
Dermatology					Orthopaedic				
Diabetes					Otology				
Endocrinology					Otorhinolaryngology				
Family Physicians (private)					Paediatric				
Gastroenterology					Pathology				
General Practice					Perinatology				
Geriatrics					Pharmacology				
Gynaecology					Plastic Surgery				
Haematology					Podiatrist				
Hand					Psychiatry				
Head and Neck					Psychology				
Infectious Disease					Radiology				
Intensive Care Medicine					Sports Medicine				
Intensivist/Urgent Care/A&E					Thoracic Surgery				
Laryngology					Transplant				
Legal and Forensic Experts					Traumatic Surgery				
Lymphangiography					Urology				
Neonatology					Vascular Surgery				
					Other				

c) Do any of the above Doctors and/or Surgeons have direct patient care responsibility at the applicant's facilities? *(if yes, please provide further details on the supplementary pages provided)*

Yes ☐ No ☐

d) Please indicate the minimum professional liability insurance limits and deductibles required for Healthcare Professionals and Medical Practitioners

Healthcare Professionals		Medical Practitioners	
£	Each and every claim	£	Each and every claim
£	In the annual aggregate	£	In the annual aggregate

e) Is evidence of cover required?

Yes ☐ No ☐

f) Has any Healthcare Professional or Medical Practitioner ever been reported to the General Medical Council? *(if yes, please provide further details on the supplementary pages provided)*

Yes ☐ No ☐

g) Please complete the following table and provide information regarding the hiring, screening and employment procedures at your facility

i) Are employees' / contractors' references contacted before hiring or placement?	Yes ☐ No ☐
ii) How are references checked?	Written ☐ Orally ☐ Both ☐
iii) Are written job descriptions created for all staff members?	Yes ☐ No ☐
iv) Does the applicant verify any pending licence suspensions, revocations or pending disciplinary actions by another facility?	Yes ☐ No ☐
v) Are full criminal background checks performed for all employees / contractors?	Yes ☐ No ☐
vi) Does the applicant utilise Criminal Records Bureau checks and for what length of time is this information retained? (if yes, please provide details on a separate sheet of paper)	Yes ☐ No ☐

h) Does the applicant have written agreements with third parties?

Yes ☐ No ☐

If yes, does each agreement include the following?

i) A mutual indemnification and hold harmless clause	Yes ☐ No ☐
ii) A requirement that the other party purchases liability insurance with liability limits equal to or exceeding the applicant's limits	Yes ☐ No ☐
iii) A requirement that the other party supplies the applicant with a current copy of the certificate of insurance	Yes ☐ No ☐

i) Are Out of Hours or Extended Hours services provided?

Yes ☐ No ☐

If yes, please provide further details outlining the following on the supplementary pages provided

i) Timeframes of when these services are provided
ii) Number of patient visits within these timeframes
iii) Services provided during these timeframes

Section 4 – Risk Management / Quality Management / Quality Improvement

a) Does the applicant utilise a formal written quality management / quality improvement plan? *(if yes, please provide further details on the supplementary pages provided)*

Yes ☐ No ☐

b) Does the applicant utilise a formal risk management plan? *(if yes, please provide further details on the supplementary pages provided)*

Yes ☐ No ☐

c) How are medical / patient records stored?

Electronic file ☐ Paper file ☐ Both ☐

i) If electronic, how often are back-up procedures performed? _____
*ii) Are any back up records stored?*_____
iii) If paper, are the buildings in which the records are stored fully sprinklered?

Yes ☐ No ☐

d) How long has the designated Risk Manager been affiliated with the entity? _____

e) How long has the designated Quality Manager been affiliated with the entity? _____

f) Are the roles of the risk manager and quality manager separate?

Yes ☐ No ☐

Section 5 – Claims History

a) Is the applicant currently aware of, or has been aware of any of the following during the past 10 years:

i)	**Any claim, circumstances, complain or proceeding brought or threatened against the applicant, or any incident which could lead to such a claim, circumstances, complaints or proceedings?**	☐ Yes ☐ No
ii)	**Any investigations or adverse findings by any professional body, tribunal, regulatory or registration body?**	☐ Yes ☐ No
iii)	**Declinature, termination, non-renewal or special conditions imposed by previous or current Insurers?**	☐ Yes ☐ No

If the answer to any of the above questions is yes, please provide the following information (where possible, on our spreadsheet attached to page 10 of this proposal form) Please note that all values should include any deductible paid by the applicant.

i) Name of third party
ii) Value of action where reserved by underwriters; if not reserved, your best evaluation
iii) Date matter advised, and date closed
iv) Legal costs and expenses incurred
v) Description of the claim

Section 6 – Previous Medical Malpractice Liability Cover

	2016	2015	2014
Insurance Company			
Limits of Liability	£	£	£
Deductible or Self Insured Retention?	☐ Deductible ☐ Self-Insured Retention	☐ Deductible ☐ Self-Insured Retention	☐ Deductible ☐ Self-Insured Retention
Deductible or Self Insured Retention amount	£	£	£
Coverage Form – Claims Made or Occurrence?	☐ Claims Made ☐ Occurrence	☐ Claims Made ☐ Occurrence	☐ Claims Made ☐ Occurrence
Retroactive Date	__ / __ / _____	__ / __ / _____	__ / __ / _____
Policy Period	Inception __ / __ / _____ Expiry __ / __ / _____	Inception __ / __ / _____ Expiry __ / __ / _____	Inception __ / __ / _____ Expiry __ / __ / _____
Premium	£	£	£

Section 7 – Requested Cover

Medical Malpractice	**Option 1**	**Option 2**	**Option 3**	**Claims Made?**
Limit of Liability (*Aggregate including Costs & Expenses*)	£	£	£	☐ Yes
Deductible (*Each and every claim including Costs & Expenses*)	£	£	£	
Professional Indemnity	**Option 1**	**Option 2**	**Option 3**	**Claims Made?**
Limit of Liability (*Aggregate including Costs & Expenses*)	£	£	£	☐ Yes
Deductible (*Each and every claim including Costs & Expenses*)	£	£	£	
Public / General Liability	**Option 1**	**Option 2**	**Option 3**	**Claims Made?**
Limit of Liability (*Aggregate including Costs & Expenses*)	£	£	£	☐ Yes
Deductible (*Each and every claim including Costs & Expenses*)	£	£	£	
Loss of Documents	**Option 1**	**Option 2**	**Option 3**	**Claims Made?**
Limit of Liability (*Aggregate including Costs & Expenses*)	£	£	£	☐ Yes
Deductible (*Each and every claim including Costs & Expenses*)	£	£	£	

Please provide details below of any coverage extensions which you request

_____

_____

Section 8 – Additional Information

Please attach as much of the following information to this proposal 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 run in Excel (please use **this** template where possible)
vi) Actuarial report if available
vii) Latest accreditation / licencing report if available

Section 9 – Declaration

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.

Signature _____

Name *(Please print)* _____

Position _____

Date _____

ALL QUESTIONS MUST BE ANSWERED AND THE PROPOSAL FORM MUST BE SIGNED AND DATED

Completing and signing this Proposal From does not bind coverage. Coverage will not be bound, nor will a policy be issued, until the applicant signifies acceptance of the Company's premium quotation

Supplementary Information

Please use this space to record the answers to any questions which additional space is required. Please make reference to the appropriate question number.

Insurance Act 2015 - Proposal Forms for non-consumer contracts - Duty of fair presentation

1. Before this insurance contract is entered into, the Insured must make a fair presentation of the risk to the Insurer, in accordance with Section 3 of the Insurance Act 2015. In summary, the Insured must:

    a) Disclose to the Insurer every material circumstance which the Insured knows or ought to know. Failing that, the Insured must give the Insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries in order to reveal material circumstances. A matter is material if it would influence the judgement of a prudent insurer as to whether to accept the risk, or the terms of the insurance (including premium);

    b) Make the disclosure in clause (1)(a) above in a reasonably clear and accessible way; and

    c) Ensure that every material representation of fact is substantially correct, and that every material representation of expectation or belief is made in good faith.

2. For the purposes of clause (1)(a) above, the Insured is expected to know the following:

    a) If the Insured is an individual, what is known to the individual and anybody who is responsible for arranging his or her insurance.

    b) If the Insured is not an individual, what is known to anybody who is part of the Insured's senior management; or anybody who is responsible for arranging the Insured's insurance.

    c) Whether the Insured is an individual or not, what should reasonably have been revealed by a reasonable search of information available to the Insured. The information may be held within the Insured's organisation, or by any third party (including but not limited to subsidiaries, affiliates, the broker, or any other person who will be covered under the insurance). If the Insured is insuring subsidiaries, affiliates or other parties, the Insurer expects that the Insured will have included them in its enquiries, and that the Insured will inform the Insurer if it has not done so. The reasonable search may be conducted by making enquiries or by any other means.

LMA9117

16 March 2016