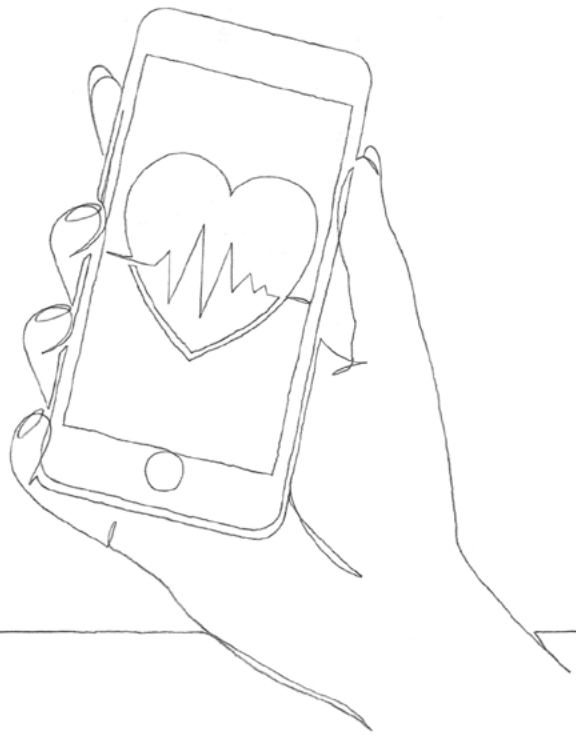
Beazley | Virtual Care



beazley

Beazley Virtual Care application

- This Application is for a claims made and reported policy. A claims made and reported policy only responds to claims made against the insured and notified to insurers during the policy period arising from any professional services wrongful act, malpractice incident, cyber incident, accident, tech services wrongful act, tech products wrongful act, act, error, omission, incident, event, conduct or matter occurring on or after the policy retroactive date.
  This Application can be completed electronically or by hand and must be signed and dated by an authorised representative of the insured organisation. 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 additional sheets as required.
- What you need to tell insurers:
- Statement pursuant to Section 25 (5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof) – You are to disclose in this Proposal Form fully and faithfully all facts which you know or ought to know, otherwise the policy issued hereunder may be void.
- 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.
- Please ensure you have signed and dated the declaration statement at the end of this Application.

Section 1 – General details

Name of your organisation:

Trading name (if different from the above):

Registered address:

Website address:

Date established: (dd/mm/yyyy) / /

Business Registration Number:

Please provide below a full description of all your professional and medical services activities:

a. What is the total gross revenue from all activities for which you require cover?

	Estimate for current financial year	Actual last complete financial year	Prior year 2	Prior year 3
(dd/mm/yyyy)	/ /	/ /	/ /	/ /
SG & HK				
Asia				
Australia / New Zealand				
USA/Canada				
Elsewhere				
(specify)				
Gross Revenue				

b. Please provide a breakdown of all your activities for the current financial year as follows:

Activity						
Healthcare		SG & HK	Asia	Australia / New Zealand	USA/ Canada	Elsewhere
Face to face patient consultations	Revenue %					
	Number of patients					
Remote telehealth patient consultations	Revenue %					
	Number of patients					
Remote Teleradiology (scanning and diagnostic) services	Revenue %					
	Number of patients					
Remote patient monitoring services	Revenue %					
	Number of patients					
Prescription fulfilment / mail order pharmacy services	Revenue %					
	Number of patients					
Laboratory or diagnostic testing services	Revenue %					
	Number of patients					

Please provide a breakdown of all your activities for the current financial year as follows:

Activity						
Technology		**SG & HK**	**Asia**	**Australia / New Zealand**	**USA/ Canada**	**Elsewhere**
Sales, distribution of packaged software	Revenue %					
Sales, distribution or licensing of your own medical technology products or software	Revenue %					
Sales or distribution of third party medical technology products	Revenue %					
IT Consulting, including consulting on hardware and/software system design	Revenue %					

Please provide a breakdown of all your activities for the current financial year as follows:

Products		**SG & HK**	**Asia**	**Australia / New Zealand**	**USA/ Canada**	**Elsewhere**
Manufacture, license, distribution or sale of wearable or mobile technology products (lifestyle)	Revenue %					
	Number of units					
Manufacture, license, distribution or sale of wearable or mobile technology products (condition management, self-care or symptom checking)	Revenue %					
	Number of units					
Manufacture, license, distribution or sale of wearable or mobile technology products (lifestyle)	Revenue %					
	Number of units					
Manufacture, license, distribution or sale of laboratory or diagnostic testing kits	Revenue %					
	Number of units					

c. Please list your three largest contracts?

Contract size	Duration	Nature of services

d. Please confirm:

i. You have all the relevant licences, authorisations or certifications in place to conduct the activities declared in this Application. Yes ☐ No ☐

ii. There are no outstanding requirements from your most recent regulatory inspection? Yes ☐ No ☐

iii. You have never been in dispute with or investigated by a regulatory or licensing body? Yes ☐ No ☐

If 'No' to either a., b., or c. above please provide details below:

e. Do any of the activities declared including those performed by third parties include the prescribing of opioids, depressants or stimulants? Yes ☐ No ☐

If 'Yes' do you:

i. track and analyse prescriptions of opioids, depressants and stimulants? Yes ☐ No ☐

ii. have systems in place to identify any unusual prescribing patterns? Yes ☐ No ☐

iii. include as part of your governance and training policies, initiatives that address the over prescribing of opioids, depressants and stimulants? Yes ☐ No ☐

If 'No' to i., ii., or iii. above please provide details of how you manage your exposure to over prescribing these drugs.

Section 2 – Medical practitioners information

a. Do you require insurance for your employed, sub-contracted, bank or locum medical practitioners as part of this application? **If 'Yes' please complete Appendix A.** Yes ☐ No ☐

i. If 'No', do you require all medical practitioners whether employed, sub-contracted, bank or locum to purchase a regulated insurance policy with a minimum Limit of Liability of USD1,000,000 in the aggregate and in all in any single policy period? Yes ☐ No ☐

ii. If you require all medical practitioners whether employed, sub-contracted, bank or locum to purchase a regulated insurance policy but the minimum Limit of Liability is less than USD1,000,000 in the aggregate, please state what the minimum Limit of Liability you require:

iii. Is evidence of valid insurance as required in a. above recorded and checked by you at least on an annual basis? Yes ☐ No ☐

b. For all Medical practitioners whether employed, contractors, sub-contractors, consultants or locums, please confirm:

i. You obtain a signed standard contract of employment or engagement before commencing work? Yes ☐ No ☐

ii. You obtain appropriate written and verbal references before hiring or placement? Yes ☐ No ☐

iii. You provide a detailed Job description? Yes ☐ No ☐

iv. You obtain a background screening check (or the equivalent in each jurisdiction you operate), prior to commencing duties Yes ☐ No ☐

v. You check they hold a valid licence to practice in the Singapore (or the equivalent in each jurisdiction you operate) and issued by a recognised licensing Body? Yes ☐ No ☐

vi. You check their credentials at least every 12 months? Yes ☐ No ☐

vii. You provide training, professional development, supervisions and appraisals necessary for them to carry out their role and responsibilities? Yes ☐ No ☐

viii. You support them to obtain further qualifications and provide evidence, where required to show that they meet the professional standards needed to continue to practice? Yes ☐ No ☐

If 'No' to any of the above, please provide details of the procedures you have in place below:

Section 3 – Media liability

a. Do you have a procedure for responding to allegations that content created, displayed or published by you is libellous, infringing, or an in breach of a third party's privacy rights? Yes No

b. Do you have a qualified legal professional review all content prior to posting? Yes No

c. Do you have a qualified medical practitioner review all medical and healthcare data and content prior to posting? Yes No

If 'No' please specify what procedures you have in place to ensure content created is legal:

Section 4 – Cyber & data privacy

Computer & network security

a. Have you suffered any known intrusions (i.e. unauthorised access) of your computer systems in the most recent past twelve (12) months? Yes No

If 'Yes', how many intrusions occurred?

Please provide details:

b. Do you mandate documented staff training for every employee user of your information systems in security issues and procedures for your Computer Systems at least on an annual basis? Yes No

Management of content and privacy exposures

i. Does the Applicant collect, process, or maintain private or personal information as part of its Business activities? Yes No

If 'Yes'

ii. Is any of this information regulated by PDPA, PDPO, the GDPR or other laws or legislation protecting private or personal information? Yes No

iii. Has the organisation implemented and completed a GDPR compliance project? Yes No

If the answer is 'No', is a project planned? Yes No

iv. Does the applicant have a legally reviewed privacy policy? Yes No

Computer system access protection

c. Does the Applicant provide remote access to its Computer Systems? Yes ☐ No ☐

If 'Yes',

i. How many users have remote access?

ii. Is remote access restricted to Virtual Private Networks (VPNs)? Yes ☐ No ☐

iii. Do you require multi-factor authentication for remote connections to your computer systems? Yes ☐ No ☐

If 'No', describe the extent to which other remote access is allowed, such as modem dial-in accounts, Remote access Servers (RAS), or dedicated Frame Relay (FR) communications.

d. Does the Applicant terminate all associated computer access and user accounts as part of the regular exit process when an employee leaves the company? Yes ☐ No ☐

e. Does the Applicant use intrusion detection software to detect unauthorized access to their network Yes ☐ No ☐

Data backup procedures

f. Is all valuable/sensitive data backed-up by the Applicant every day and stored securely? Yes ☐ No ☐

If 'No', please describe exceptions:

Data encryption procedures

g. Does the Applicant have and enforce policies concerning when internal and external communication should be encrypted? Yes ☐ No ☐

If 'Yes', describe the types of 1) internal and 2) external communications which are encrypted.

h. Does the applicant have and enforce policies concerning encryption for data at rest? Yes ☐ No ☐

i. Does the applicant have and enforce policies concerning encryption for mobile devices and media (backup tapes)? Yes ☐ No ☐

PCI compliance

j. Please state how payment card transactions you (including a third party payment processor on your behalf) process each year:

- a. more than 6 million
- b. 1 million to 6 million
- c. 20,000 to 1 million
- d. less than 20,000

k. Are you currently compliant with the PCI Data Security Standards latest PCI Version — Yes / No

l. Has the application undergone PA-DSS validation? — Yes / No

If 'No', to any of the above please provide further information and/or list the name and version of software application(s) here:

m. Do you store consumer card data in your systems for future transactions? — Yes / No

n. Do you employ Tokenization or end-to-end encryption including tokenization (encryption of databases) to protect payment card data? — Yes / No

o. Are employees, administrators, or vendors with remote access to payment systems or no applications authenticated using a 2-factor authentication mechanism? — Yes / No

Section 5 – Public liability

Please confirm:

a. Away from your premises, you do not perform any physical manual work — Yes / No

b. At your premises, you only perform activities associated with the normal running of an office — Yes / No

c. You do not own or use any buildings or space outside of the country stated in this proposal form — Yes / No

Section 6 – Legal expenses

Please confirm:

a. You have never been refused insurance or had terms imposed on any previous policy — Yes / No

b. During the last three years, you have not been involved in any legal dispute that would have been covered by this policy and exceeds USD5,000 — Yes / No

c. During the last six months, or within the next 12 months, you have not made nor do you envisage making any structural change(s) to the business which has or may result in any redundancies — Yes / No

Section 7 – Operational expenses

Contracts

a. Do your written contracts with customers, clients, vendors or suppliers include:

i. a mutual indemnification and hold harmless clause — Yes ☐ No ☐

ii. a requirement that the third party purchases liability insurance with liability limits equal to or exceeding your limits. — Yes ☐ No ☐

If 'No' to i., ii. above please provide further details below:

b. Are all written contracts approved by a qualified legal professional prior to signing? — Yes ☐ No ☐

c. Is a written contract always signed prior to the commencement of services? — Yes ☐ No ☐

Patient experience

a. Do you have a formal programme for clinical quality assurance? — Yes ☐ No ☐

b. Do you have a complaints policy and dedicated complaints handling officer for each geographical location you are operate? — Yes ☐ No ☐

Document retention

a. Please confirm you have a document retention policy for the following documents and records which includes a contingency for long-term secure storage if you cease to trade:

We may require access to these documents and records in the investigation or defence of a claim.

i.	medical / patient records	Yes	No
ii.	obstetric records retained indefinitely	Yes	No
iii.	electronic Fetal monitoring and Cardiotocography (EFM/CTG) readings Indefinitely	Yes	No
iv.	employment applications, declarations, references, identity checks for all your staff and contractors	Yes	No
v.	training records for all staff and contractors	Yes	No
vi.	Serious Incident Reports	Yes	No

b. Do you maintain a record of all requests on behalf of patients for medical records? Yes No

Section 8 – Claims history

Are you currently aware of, after full enquiry, any of the following during the past 5 years relating to the proposed insurance and cover extensions?

i.	Any claim or potential claim, circumstance, complaint, demand or proceeding brought or threatened against your organisation, or any of your directors, employee for any incident which could lead to such a claim, circumstance, complaint or proceeding?	Yes	No
ii.	Any investigation, inquiry or adverse finding by any professional body, tribunal, Government, regulatory or registration body against your organisation, or any of your directors, employee?	Yes	No
iii.	The declinature of a claim or potential claim, circumstance, complaint, demand or proceeding brought or threatened by previous or current insurer?	Yes	No
iv.	The cancellation, non-renewal or special conditions imposed by your previous or current insurer?	Yes	No

If the answer is 'Yes' to i., ii., iii., or iv. above, please provide full details:

Section 9 – Previous cover

	Insurer	Limit of liability	Excess/ deductible	Retro-active date	Start or renewal date	Premium
Medical malpractice						
Tech E&O						
Cyber/breach response						
Public liability						
Products liability						

Section 10 – Cover requirements

Limit	Limit of liability	Excess/deductible	Retro-active date
Medical malpractice			
Tech E&O			
Cyber/breach response			
Public liability			
Products liability			

Section 11 – Declaration

Please use the supplementary page(s) to add any pertinent information or additional information as may be required to fully answer the questions.

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

I/we undertake to inform insurers of any material alteration to these facts occurring before the completion of the contract of insurance. However, the duty to disclose material facts continues after the completion of the Application and throughout any policy period (and any extension thereto).

Statement pursuant to Section 25 (5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof) - You are to disclose in this Proposal Form fully and faithfully all facts which you know or ought to know, otherwise the policy issued hereunder may be void.

Signing this Declaration does not bind the proposer to complete this insurance.

Signature:

Print name:

Position held (Owner, partner, authorized officer):

Title:

Date: / /

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED

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

Appendix A – Medical practitioners

Please tell us the number of Full Time Equivalents (FTEs)

Cover required	Number of employed	Has own malpractice insurance		Number of independent contractors	Has own malpractice insurance	
		Yes	No		Yes	No
Acupuncturists						
Adult Nurses						
Advanced Nurse Practitioners						
Advanced Paramedics						
Advanced Pharmacists						
Allied Healthcare Practitioner						
Call Handlers						
Care Worker						
Children's Nurse						
Clinical Nurse Specialists						
Clinical Shift Managers						
Complementary Medicine Practitioner						
Counsellors						
Critical Care (Outreach) Nurse						
District Nurse						
Health Care Assistants						
ICU/NICU Nurses						
Lab Technicians						

Cover required	Number of employed	Has own malpractice insurance		Number of independent contractors	Has own malpractice insurance	
		Yes	No		Yes	No
Mental Health Nurses						
Midwives						
Occupational Therapists						
Osteopaths						
Paramedics						
Pharmacy Assistants						
Pharmacists						
Physician Assistants						
Physiotherapists						
Prescribing Pharmacist						
Radiographers						
Registered Nurses						
Sonographers & Scanners						
Staff /Charge / Ward Nurses						
Students						
Theatre Nurses						
Triage Nurses						
Other						
(please specify)						

Please tell us the number of Full Time Equivalents (FTEs) Doctors and Consultants:

Cover required	Number of employed	Has own malpractice insurance		Number of independent contractors	Has own malpractice insurance	
		Yes	No		Yes	No
A&E / Trauma						
Bariatric/weight loss						
Cardiology						
Colorectal						
Cytopathology						
Dentistry						
Dermatology						
Diabetic						
Endocrinology						
Elderly Medicine						
Embryologists						
Gastroenterology						
General Medicine (Internal)						
General Practice (NHS)						
General Practice (Private)						
Geneticists						
Haematology						
Infectious diseases						

Cover required	Number of employed	Has own malpractice insurance		Number of independent contractors	Has own malpractice insurance	
		Yes	No		Yes	No
Nuclear Medicine						
Neonatal						
Obstetrics / Gynaecology						
Occupational Medicine						
Oncology						
Ophthalmology						
Optometrists						
Orthopaedic						
Pathology						
Paediatric						
Podiatry						
Plastic (non elective)						
Plastic (elective)						
Psychiatric						
Radiologist						
Urology /Renal						
Resident Medical Officer						
Other						
(please specify)						

Supplementary information

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