

## COMPLEMENTARY MEDICAL PRACTITIONERS PROPOSAL FORM

Please read the following questions carefully and answer them all providing additional information where required. Should you require more space please provide answers on a separate sheet of paper.

Answer the question using **BLOCK CAPITALS** and tick boxes where appropriate.

### 1. PROPOSERS DETAILS

Full name of the Proposer

Date of birth

Trading name (if different from the above)

Have you ever engaged in a similar activity under a different name?

YES

NO

If YES please give full details

Address of Proposer

Practice/trading address (if different from above)

If cover is required for more than one location please attach a list of all addresses

## 2: THE BUSINESS

Please state your total Gross Fee Income/ Turnover/ Gross Receipts:

For the past financial year
Estimate for the current financial year

Total number of treatments/sessions/consultations?

Do you work as an individual practitioner/therapist?

YES

NO

Where and when did you qualify?

Please give full details of what patient records are kept, where and how they are stored and for how long they are retained:

**Please note it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.**

**Please provide a copy of your certificates/diplomas with the application.**

In what branch or branches of complementary medicine are you qualified and, if applicable, licensed to practice, please tick the appropriate boxes:

Acupuncture		Kinesiology	
Acupressure		Light touch therapy	
Allergy testing		Massage	
Alexander technique		Moxibustion	
Aromatherapy		Music therapy	
Ayurveda		Naturopathy	
Bach remedies		Neuro-linguistic-programming	
Baxes method		Nutrition therapy	
Colonic irrigation		On site massage	
Colour therapy		Polarity therapy	
Counselling		Psychology	
Crystal therapy		Radionics	
Craniosacral therapy		Reflexology	
Healing/reiki		Rolfing	
Herbalism		Sports massage	
Hypnotherapy		Stress counselling	
Indian head massage		Touch for health	
Iridology		Yoga	
OTHER, please specify:			

Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed

	EMPLOYED	SELF-EMPLOYED
The PROPOSER'S PRIVATE PRACTICE		
CLINICS		

PRIVATE NON-SURGICAL NURSING:

HOMES AND HOSPICES		
PATIENTS' HOMES		

OTHER (PLEASE SPECIFY)


If you are an employee please state the name of the company (or other entity) for whom you work:

Has the Proposer or any employee involved on the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries?

YES  NO

If YES please give full details

Are you a member of any professional organisation, or registered with any self-regulating body?

YES  NO

If YES please state which and period of membership/registration:



Has membership or registration with such organisation/body ever been suspended, withdrawn, amended or declined or had conditions attached?

YES

NO

If YES please give full details

If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance?

YES

NO

### 3. INSURANCE COVER

Has the Proposer previously purchased Professional Indemnity Insurance?

YES

NO

If YES please provide the following information:

Name of Insurers:
Expiry date:
Indemnity Limit:
Deductible:
Retroactive Date:

Has an insurer ever:

Declined a proposal or a renewal for this insurance?

YES

NO

Imposed special terms or increased premium other than standard market increases?

YES

NO

Cancelled the insurance?

YES

NO

If YES to any of the above questions please provide details below:

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What is the limit you now require:

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Deductible:

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#### 4. CLAIMS INFORMATION

Is the Proposer aware of any fraud, dishonesty, bankruptcy or administration order applicable to the Proposer and/or any past or present principal, partner, director or employee?

YES

NO

If YES please provide details:

Has any claim been made against the Proposer's business or against any principal, partner, director or employee whilst in this or any other business?

YES

NO

If YES please provide details:

Is the Proposer aware of any circumstance or incident which has or could result in any claim being made against the Proposer's business or against any principal, partner, director or employee whilst in this or any other business?

YES

NO

If YES please provide details:

## 5. DECLARATION

I/we declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatsoever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/We will advise Underwriters as soon as is practicable.

I/We understand that failure to disclose any material facts which would influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the possibility in every respect.

I/We hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.

SIGNATURE

POSITION

NAME

DATE



**ADDENDUM 1**

To be completed if not an individual practitioner/therapist

Number of qualified practitioners/therapists?

Details of Directors/Partners/Practitioners/Therapists

NAME	QUALIFICATIONS/ EXPERIENCE DETAILS	EMPLOYED OR SELF EMPLOYED

Please provide full details of any equipment used to perform treatment or therapy (on a separate sheet of paper or use the space below) and attach any relevant brochure.

Please provide details of all information given out i.e. brochures and literature.

Please list addresses of each location you operate from (on a separate sheet of paper or use the space below).

Do you subcontract any work out?

YES

NO

If YES please give full details

What limit of indemnity do you require your sub contractors to insure for?

Please provide a copy of your standard form agreement/contract or letter of appointment.



PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE.

A large, empty rectangular box with a thin blue border, intended for recording answers to questions that require additional space.