Peninsula
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MEDICAL ESTABLISHMENT 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. PROPOSER'S DETAILS

Full Name of Proposer

Address of Proposer

Practice address if different from above

Contact details (tel, fax, e-mail, website)

If cover is required for more than one location please list them below:

Please name the ultimate Owner or Holding Company:

Please state any corporate or private entity of either USA or Canadian origin, that has any ownership or interest in either the Proposer or the Proposer's ultimate owner or holding company and their percentage holding.

Length of current operation by present Parent/ Owner:

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2. THE BUSINESS

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

For the past financial year
Estimate for the current financial year

Please give a full description of your business activities for which cover is required (this must be answered):

What percentage of funds are generated from:

Government/ public	%	
Private funding	%	
Charitable donations	%	

What are the approximate percentages of patients from:

Government/ public	%	
Private funding	%	
Charitable donations	%	

What, if any, substantial changes in your activities or major new developments are likely to occur within the next 12 months?
Please give full details.

Are you licensed and registered in accordance with the applicable regulatory body or law to practise those procedures at the address specified in Question 3 for which indemnification is required?

YES ☐ NO ☐

If NO please give full details

Are you a member of any Association or Professional Body, or registered with any self-regulating Organisation?

YES ☐ NO ☐

If YES please state which:

Has membership or registration with such ever been suspended, withdrawn, amended, declined or had conditions attached?

YES ☐ NO ☐

If YES please give full details

Does the establishment have:

C.A.T/ M.R.I. Scanners or similar?

YES ☐ NO ☐

If YES please provide details of any maintenance agreement:

Medical teaching facilities?

YES ☐ NO ☐

Nursing teaching facilities?

YES ☐ NO ☐

Pathology Laboratory?

YES ☐ NO ☐

Any ambulance owned?

YES ☐ NO ☐

Any air ambulance owned/operated?

YES ☐ NO ☐

Please state the total number of beds and average daily occupancy:

	NUMBER	A.D.O
Beds		%
Bassinets/ Cribs/ Cots		%
I.C.U./ I.T.U.		%

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Please state the total number of admitted in-patients:

LAST YEAR
% of patients from USA & CANADA

Please identify the approximate percentage of procedures performed on ADMITTED in-patients within the following categories:

Where indicated with an * please complete sections of the Addenda as indicated.

Accident & Emergency* (Addendum 5)	
Assisted Conception* (Addendum 1)	
Clinical Trials* (Addendum 2)	
Communicable Diseases	
Drug/ Alcohol Dependency	
Dental	
Elective Cosmetic	
Elective T.O.P* (Addendum 4)	
Gender Reassignment	
Geriatric	
Maternity/ Obstetrics* (Addenda 3 & 5)	
Organ Transplant	
Paediatric	
Psychiatric	
Tropical Diseases	
Other Minor Surgery	
Intermediate Surgery	
Major Surgery	
Keyhole Surgery	
	TOTAL 100%

Please state the number of Operating Theatres:

Please specify the approximate number of patients treated and percentage of Gross Fee Income / Turnover / Gross Receipts derived during the past Financial year.

	PATIENTS PER ANNUM	% OF TOTAL INCOME
Antenatal Clinic		
Assisted Conception		
Dental		
Elective Cosmetic		
Elective T.O.P		
HIV/ HEP (inc Counselling)		
Laser Eye Surgery		
Nutrition/ Diet/ Slimming		
S.T.D.		
Sports Injury		
Well Man		
Well Woman		
Other Medical (please give details)		
TOTAL		

PLEASE NOTE THAT THIS POLICY IS DESIGNED TO COVER CLAIMS MADE AGAINST THE PROPOSER. IF COVER IS ALSO REQUIRED FOR CLAIMS MADE AGAINST REGISTERED MEDICAL PRACTITIONERS FOR WORK PERFORMED AT THE INSURED, PLEASE SUPPLY A LIST OF ALL DOCTORS FOR WHOM COVERAGE IS REQUIRED STATING THE NAME, D.O.B., QUALIFICATIONS AND PRACTICE OF EACH DOCTOR. IN ADDITION TO THIS PLEASE CONFIRM WHETHER OR NOT THE DOCTORS ARE EMPLOYED BY THE PROPOSER OR SELF-EMPLOYED.

Please state the total number of persons involved in the following capacities:

Non procedural Physicians:

Psychiatrists		
Other		

Surgeons:

Cosmetic		
Orthopaedic		
Other		

Anaesthetists		
Obstetricians		
Gynaecologists		
Lab/Path technicians		
Dentists		
Midwives		
Nurse Practitioners		
Nurse Anaesthetists		
Nurses - Day		
Nurses - Night		
Pharmacists		
Paramedics		
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries - Qualified		
Auxiliaries - Non-Qualified		
Counsellors		
Directors/Partners/Principals		
Clerical/Administration		
Other (please specify)		

Do you ensure and record that at all times all Registered Medical and Dental Practitioners are members of a Medical/ Dental Defence Organisation, recognised by your National Medical/ Dental Association, or are otherwise fully Insured for their own Malpractice?

YES ☐ NO ☐

If the answer is NO refer to the **Note** above.

Are any counselling services made available to patients?

YES ☐ NO ☐

If YES please indicate in which of the following categories:

	NUMBER OF COUNSELLORS	EMPLOYED	SELF EMPLOYED	NUMBER OF PATIENTS
Assisted Conception				
Drug/Alcohol Dependency				
Elective Cosmetic				
Elective T.O.P				
Gender Reassignment				
HIV/HEP/STD				
Sterilisation				
Other (please specify)				

Do all Counsellors hold appropriate qualifications?

YES ☐ NO ☐

Please provide details

Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e Hepatitis, H.I.V. etc. or other impediment which may affect the performance of his/her professional duties or place patients/clients at risk?

YES ☐ NO ☐

If YES what procedures are in place:

Do you have a blood bank?

YES ☐ NO ☐

Please state average number of units of blood or blood products used by your Establishment in any one calendar month.

Is 100% of the above bought or obtained from your National Blood Transfusion Service or National Red Cross?

YES ☐ NO ☐

If NO please give full details:

Are all blood or blood products tested for transmittable diseases in accordance with the National Blood Transfusion Service, National Red Cross Society or an equivalent body prior to use?

YES ☐ NO ☐

If YES please list all tests carried out

If NO please give full details

Please provide full details of storage facilities and procedures:

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

Please note that 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.

Do you provide facilities for the sterilisation of instruments in accordance with current guidelines?

YES ☐ NO ☐

If NO please provide details of what arrangements are in place for this:

If YES do you ensure that effective cross-infection control methods are employed?

Do you have a protocol for needlestick injuries?

YES ☐ NO ☐

If NO please give full details:

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:

What is the indemnity limit you now require:

What is the deductible you now require:

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 - ASSISTED CONCEPTION

If an assisted conception unit is maintained, please give full percentage breakdown of the number of cycles undertaken:

A.I.H
A.I.D
I.V.F / E.T / P.R.O.S.T
FROZEN EMBRYO REPLACEMENT
G.I.F.T
OTHERS - please specify and indicate numbers

Are counselling services made available to patients?

YES ☐ NO ☐

Is all donor semen screened, cryopreserved and quarantined in line with current recommendations?

YES ☐ NO ☐

ADDENDUM 2 - CLINICAL TRIALS

Please state for whom Clinical research Projects are undertaken e.g. pharmaceutical and manufacturers, Charities, Research Foundations etc

Do you receive a full indemnity from your Principals?

YES ☐ NO ☐

Do all volunteers sign an Informed Consent Form?

YES ☐ NO ☐

If double blind studies are undertaken are volunteers made fully aware of this?

YES ☐ NO ☐

Do any trials involve and female volunteers of child-bearing age?

YES ☐ NO ☐

If YES please provide full details:

Please state the Annual Income or Turnover

Please state the number of trials during the past 12 months detailing the number of volunteers:

Please state the anticipated number of trials with which you will be involved during the next 12 months detailing the number of volunteers in each trial:

Do you conduct any formal research, testing or experimental activities in the following categories:

Transplant
Artificial Organ
Surgery
YES ☐

Human Embryo Research
Genetic Engineering
Obstetrics
NO ☐

ADDENDUM 3 - MATERNITY / OBSTETRICS

Please state the number of Deliveries Per Annum	
Including: Multiple Births	
Healthy Neonatals	
Stillborn Infants	
Infants delivered at less than 32 weeks gestation	
Infants delivered at less than 1501grammes	
Infants with an Apgar rate of less than 6 at five minutes:	
TOTAL Number of Infants admitted to the NICU/SCBU:	
(i) From your own obstetrics Department	
(ii) Transferred from entities outside the control of the Proposer	

Is an Obstetrician available in-house 24 HOURS PER DAY?
YES ☐ NO ☐

Is a second Obstetrician on call 24 hours per day who is able to attend within 30 minutes?
YES ☐ NO ☐

Is a Paediatrician available in-house 24 hours per day?
YES ☐ NO ☐

Is an Anaesthetist available in house 24 hours a day?
YES ☐ NO ☐

Is an Anaesthetist available solely to the obstetrical department 24 hours a day?
YES ☐ NO ☐

Is a second Anaesthetist on call 24 hours per day who is able to attend within 30 minutes?

YES ☐ NO ☐

Can midwives attend births without attending doctors?

YES ☐ NO ☐

Please give brief details of the Proposers Policy in respect of mother & foetal monitoring:

Do you offer counselling service for parents following a miscarriage, or perinatal death, or the birth of a handicapped child?

YES ☐ NO ☐

ADDENDUM 4 - ELECTIVE TERMINATION OF PREGNANCY

If elective T.O.P.'s are undertaken, please provide a full breakdown of the numbers of procedures by gestation period at time of termination

Upto 12 Weeks	
12 - 16 weeks	
16 - 20 weeks	
20 - 24 weeks	
Over 24 weeks	

ADDENDUM 5 - EMERGENCY CARE

Please indicate which of the following best describes the extent of emergency care provided by the Insured (please tick box):

(i) Comprehensive emergency care is available 24 hours a day and includes anaesthetic, medical & surgical services by resident staff, with other speciality consultation available within approximately 30minutes

YES ☐

(ii)A Doctor is always present in the emergency care area with speciality consultation available within approximately 30 minutes

YES ☐

(iii) Emergency care is provided approximately 30 minutes through a medical staff call roster

YES ☐