Peninsula
UNDERWRITING • LTD

REGISTERED 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 Proposer

Address of Proposer

Trading address if different to above:

Date Proposer established

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

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

YES ☐ NO ☐

If YES please give full details:

IF COVER IS REQUIRED FOR MORE THAN ONE LOCATION, PLEASE ATTACH A LIST OF ALL ADDRESSES.

At which Medical / Dental School did you qualify, and in what year?

Please also state type of degree:

Please give details of any additional or post graduate qualifications:

Please state:
The name of your registration or licensing body:

Your registration number:

Your registration date:

Date of first registration:

Are there now or have there ever been any conditions attached to your registration?

YES ☐ NO ☐

Has there ever been any interruption in your registration?

YES ☐ NO ☐

If YES please provide full details:

2: THE BUSINESS

In what branch or branches of medicine are you qualified and licensed to practice, please tick:

Anaesthesiology		Ophthalmology*	
Cardiology		Orthopaedics	
Community Medicine		Orthodontics	
Dermatology		Otorhinolaryngology	
Dentistry*		Paediatrics	
Endocrinology		Pathology	
General Practice		Pharmacology	
Genetics		Physiology	
Haematology		Psychiatry	
Immunology		Radiotherapeutics	
Industrial Health		Rehabilitation	
Neurology		Surgery*	
Nuclear Medicine		Tropical Medicine	
Nutrition		Venereology	
Obstetrics/Gynaecology*		Other, please specify	

Where marked with an * please complete the relevant sections of the Addenda.

If you are either a G.P. or Obstetrician/Gynaecologist please state the number of :

Emergency non hospitals births you attended in the last 12 months:	
Routine home births you attended in the last 12 months:	

If you are a Surgeon please give full details of the type of surgery performed, e.g. Cardiac/ Gender Reassignment / Elective Cosmetic / Elective T.O.P. / Organ Transplant / Keyhole / Laser Eye or other Major or Intermediate or Minor Surgery:

Are you involved in Clinical trials for which you require cover?

YES ☐ NO ☐

If "Yes" are you under contract with a third party to conduct trials on their behalf?

If "Yes" to whom are you under contract?

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 any female volunteers of child-bearing age?

YES ☐ NO ☐

If "YES" please attach full details.

Please state the number of trials performed during the last 12 months detailing the number of volunteers in each trial:

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?

	YES	NO		YES	NO
Transplant			Human Embryo Research		
Surgery			Artificial Organ		
Genetic Engineering			Obstetrics		

If "YES" please attach full details.

PLEASE PROVIDE COPIES OF YOUR INFORMED CONSENT FORM & ANY INDEMNITIES REFERRED TO IN THE QUESTIONS

Please give full details of what patient records are kept, where & 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 case of minors, 10 years from majority.

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

For the past financial year	
Estimate for the current financial year	

Do you own (wholly or in part), operate or administer any hospital, nursing home or any other medical establishment?

YES ☐ NO ☐

IF THE ANSWER IS "YES" AN ADDITIONAL PROPOSAL FORM WILL HAVE TO BE COMPLETED BEFORE QUOTATIONS CAN BE GIVEN

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		
Public Sector Hospitals / Homes		
Private Surgical Hospitals / Homes		
Private Non-Surgical Homes		
Patient's Homes		
Other (please specify)		
TOTAL		

If you are an employee, please state the name of the employing authority or the name of the private hospital or company for which you work.

Please state the number of staff and give details of the capacity in which they practice:

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

YES ☐ NO ☐

If "YES" what procedures are in place?

Has the Proposer or any member of staff involved in 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 organization, or registered with any self regulating body?

YES ☐ NO ☐

If "YES" please give full details:

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

YES ☐ NO ☐

If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance or that you be a member of any Defence Organisation?

YES ☐ NO ☐

If "YES" 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 - DENTISTRY

Are general anaesthetics ever administered?

YES ☐ NO ☐

Do you personally administer general anaesthetics?

YES ☐ NO ☐

Do you have appropriate post-graduate training and relevant experience in the use of anaesthetic drugs for dental purposes?

YES ☐ NO ☐

If "YES" please provide details:

Does a Dentist other than yourself treat the patient?

YES ☐ NO ☐

If the answer to the second question is "NO" is the anaesthetic administered by a dental or medical practitioner with appropriate post-graduate training and relevant experience in the use of anaesthetic drugs for dental purposes?

YES ☐ NO ☐

Does the person administering the anaesthetic (the 'Anaesthetist') always remain with the patient throughout the anaesthetic procedure and until the patient's protective reflexes have returned and the patient has recovered control of his / her own airway?

YES ☐ NO ☐

How many assistants are present throughout the procedure?

Does the 'Anaesthetist' always have an assistant in support throughout the procedure and recovery?

YES ☐ NO ☐

If "YES" is the assistant specifically trained and experienced to assist in monitoring the patient's condition and in any emergency?

YES ☐ NO ☐

Is the person providing the dental treatment always assisted by a dental surgery assistant / dental nurse?

YES ☐ NO ☐

Is sedation ever administered?

YES ☐ NO ☐

If "YES", Is this personally administered by you?

YES ☐ NO ☐

If "NO" please indicate the type of practitioner who administers the sedation (e.g. Dentist or Anaesthetist):

What type of sedation is administered, please tick?

Intravenous	
Inhalational	
RA	

If you have indicated intravenous sedation, does the practitioner administering the sedation have post-graduate training in this procedure?

YES ☐ NO ☐

Is a dental surgery assistant / dental nurse present throughout the procedure?

YES ☐ NO ☐

If "YES" does he /she have training and experience in assisting in procedures of sedation, including monitoring the clinical condition of the patient and assisting in an emergency?

YES ☐ NO ☐

Is the operating room equipped with continuously-acting monitoring devices and a defibrillator?

YES ☐ NO ☐

Is there basic life support equipment setup ready for use in the operating room?

YES ☐ NO ☐

Are patients ever left unattended whilst under general anaesthesia or sedation or in recovery?

YES ☐ NO ☐

Is a full medical history of the patient always taken prior to administration of general anaesthesia or sedation?

YES ☐ NO ☐

Are patients always given written pre- and post-treatment instructions in advance of the procedure?

YES ☐ NO ☐

ADDENDUM 2 - OBSTETRICS / GYNAECOLOGY / SURGEONS

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 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 ☐

Are facilities available to you for emergency Caesarean sections to be performed 24 hours per day?

YES ☐ NO ☐

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

YES ☐ NO ☐

Is a Paediatrician available 'in-house' 24 hours per day?

YES ☐ NO ☐

ADDENDUM 3 - OPTHALMOLOGY

Do you perform laser eye surgery?

YES ☐ NO ☐

If "YES" please provide full details:

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