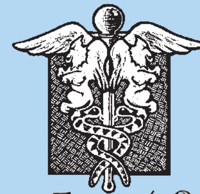
CORPORATE HEALTH PROVIDERS MEDICAL PROFESSIONAL LIABILITY

BROKER / INSURANCE AGENT



Marketform®

Syndicate 2468 at Lloyd's and / or Acting as agent for Syndicate 2468 at Lloyd's

PLEASE READ THESE GUIDANCE NOTES BEFORE COMPLETING THE PROPOSAL FORM. WHERE FURTHER INFORMATION IS REQUIRED PLEASE REFER TO YOUR BROKER/INSURANCE AGENT.

PLEASE NOTE This Proposal Form is for a CLAIMS MADE policy. A CLAIMS MADE policy only responds to "claims" made against the Insured and notified to Underwriters during the period of insurance.

- This Proposal Form must be typed, or completed in ink and signed and dated by the Proposer. Please answer every question fully, and state "NIL" or "NONE" as applicable. Incomplete answers may not be accepted and can delay quotation.
- Where more than one location or Company / Firm is to be included in the quotation, please complete a separate proposal form for each location or Company / Firm.
- Please submit, with the Proposal, all relevant information including Financial Report and Accounts, Brochures, Consent Forms etc.
- Should there be insufficient room in the Proposal Form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.
- It is the duty of the Proposer to disclose all material facts to Underwriters. Where this is omitted, the Underwriters may avoid their obligation under the Policy.

  For the purpose of the Proposal and for all purposes relating to any policy issued pursuant to this Proposal, a 'material fact' shall be deemed to be one that would be likely to influence an Underwriter's judgment and acceptance of your Proposal.
- Upon acceptance of the Underwriters' terms and conditions and payment of the premium, all information provided by the Proposer together with the guidance notes will be deemed to be incorporated in the contract between Underwriters and the Insured.

Copies of the Proposal Forms should be retained for your own records.

1. i) Full name of the Insured:

ii) Trading name if different from above:

iii) How long has the establishment been trading under the above name?

2. Has the Insured or its principals engaged in any Healthcare activities under a different title in the last five years. If so, please provide details on a separate sheet identifying: Title, Trading and Registered Address, Nature of services.

3. i) Trading address:

Postal Code: ________ Country: ________

Telephone Number: ________

Facsimile Number: ________

ii) Registered Office (if different from above):

Postal Code: ________ Country: ________

Telephone Number: ________

Facsimile Number: ________

NB: If cover is required for additional locations, a separate proposal form for each must be completed.

SIGNING OF THIS PROPOSAL FORM DOES NOT BIND THE PROPOSER OR UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE

Notice to Proposers resident in the EU

The parties completing this Contract are free to choose the law applicable to this Contract. However, unless it is specifically agreed to the contrary, the Contract shall be subject to the law of the Country stipulated in the applicable EC Insurances pre-contractually required in accordance with the Third EU Non-Life Directive.

8 Lloyd's Avenue, London EC3N 3EL
Tel No. +44 (0)20 7488 7700 Fax No. +44 (0)20 7488 7800
INTERNET. http://www.marketform.com E-MAIL. info@marketform.com

©Marketform, September 2006

4. i) Please name the ultimate Owner or Holding Company:

ii) Please identify any corporate or private entity of either USA or Canadian origin, that has any ownership or interest in either the Insured or the Insured's ultimate owner or holding Company and their percentage holding.

iii) Length of current operation by present Parent / Owner:

5. i) Please state your total Gross Fee Income / Turnover / Gross Receipts (excluding sale of goods):

a) for the past Financial Year

b) estimate for the current Financial Year

ii) Please state the approximate number of patients / clients:

a) during your last Financial Year

b) during your current Financial Year

6. i) **PLEASE GIVE A FULL DESCRIPTION OF YOUR BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (this must be answered):**

ii) Please tick if you are involved in any of the following and where indicated*, complete the relevant Addendum.

		% total income
Assisted Conception Unit*		
Autologous Bloodbank		
Clinical Research Establishment*		
Health & Fitness Centre / Gym*		
Industrial / Occupational Health & Safety*		
Health Screening Centre / Mobile Unit*		
Inoculation / Travel Centre		
Medical Personnel / Employment Agency*		
Medical teaching facility		
Nursing teaching facility		
Pathology Laboratory*		
Repatriation &/or Ambulance Service*		

iii) 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:

7. i) 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 explanation why not:

ii) Please identify your memberships or registration with Association or Professional Bodies or Licensing Authorities.

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

YES ☐ NO ☐

If 'YES' please give full details:

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

8. 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' please refer to the Note above.

©Marketform, September 2006

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

	EMPLOYED BY THE INSURED	**SELF-EMPLOYED**
Non procedural Physicians:		
Psychiatrists		
Other		
Surgeons:		
Cosmetic		
Orthopaedic		
Other		
Anaesthetists		
Obstetricians		
Gynaecologists		
Lab/Path technicians		
Dentists		
Midwives		
Nurse Anaesthetists		
Nurses - Day		
Nurses - Night		
Pharmacists		
Paramedics		
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries - Day		
Auxiliaries - Night		
Counsellors		
Directors/Partners/Principals		
Clerical/Administration		

Other (please specify):

10. Are any counselling services made available to patients?

YES ☐ NO ☐

If 'YES':

i) 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):

ii) Do all Counsellors hold appropriate qualifications?

YES ☐ NO ☐

Please provide details:

11. 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:

12. i) Please state:

Total number of Day Care Beds:

Total number of Overnight Beds:

ii) Please state what, if any, percentage of patients / clients in the last year came from USA or Canada: %

iii) Please state what, if any, percentage of the patients / clients in the last year who may be resident in Britain come from USA or Canada: %

13. i) Do you provide facilities for the sterilisation of instruments in accordance with current guidlines?

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?

ii) Do you have a protocol for needlestick injuries?

YES ☐ NO ☐

If 'NO' please give full details:

©Marketform, September 2006

14. 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.

If you require Public Liability Insurance please complete the following section:

PREMISES COVERAGE

15. Please give full details about the premises, including number of buildings and their age and any anticipated material developments:

i) Number of buildings?

ii) Please give brief details of legislation that applies to the testing and servicing of water tanks, air conditioning units etc:

iii) Are lifts, hoists, escalators and the like regularly serviced under contract?

YES ☐ NO ☐

iv) a) What premises functions or facilities do you sub contract?

b) What systems are in place to ensure that those sub contractors carry adequate insurance and name your organisation as an additional Insured to their insurances?

16. i) Do the Premises comply with current fire precaution/ prevention requirements?

YES ☐ NO ☐

If 'NO' give details:

ii) Are staff instructed and kept regularly appraised in fire and emergency procedures?

YES ☐ NO ☐

iii) Do the premises have an emergency electrical system?

YES ☐ NO ☐

17. i) Do you provide facilities for safe collection, storage and disposal in accordance with current guidelines / legislation of:

a) 'Sharps'? YES ☐ NO ☐

b) Dressings, clinical / surgical waste etc? YES ☐ NO ☐

ii) Do you ensure that the following are safely disposed of in accordance with current guidelines / legislation:

a) all blood / blood products? YES ☐ NO ☐

b) all other waste? YES ☐ NO ☐

PREVIOUS INSURANCE HISTORY

PLEASE REFER TO YOUR BROKER/INSURANCE AGENT IF YOU ARE IN ANY DOUBT AS TO WHAT IS BEING ASKED OF YOU IN THIS SECTION

FOR EACH POLICY:

18. i) Who are the present Medical Professional and / or Public Liability Underwriters of the Insured?

ii) Has prior coverage been on a CLAIMS MADE BASIS?

YES ☐ NO ☐

iii) If 'YES' what is the retroactive date?

©Marketform, September 2006

iv) What are the present policy limits of insurance?

v) What is the amount of self insured excess for each policy?

vi) What is the expiry date of the present policies?

19. Has any application for these type of insurance cover ever been:

i) declined? YES ☐ NO ☐

ii) cancelled? YES ☐ NO ☐

iii) required special terms? YES ☐ NO ☐

If the answer to any of the above is 'YES' please give details:

PREVIOUS CLAIMS HISTORY

20. i) List all claims made against the Insured during the last 10 years for all Sections of cover requested. **IF NONE, PLEASE STATE "NONE"**:

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the allegations details of Claimant

ii) List all circumstances/complaints which may give rise to a claim being made against the Insured for all Sections of cover requested.
IF NONE, PLEASE STATE "NONE":

Date of Circumstance / Complaint	Details including nature of the Complaint and details of the Complainant

21. i) Have all of the above in question 20 been notified to your previous Underwriters? YES ☐ NO ☐

ii) Have all of the above been accepted by your previous Underwriters? YES ☐ NO ☐

©Marketform, September 2006

22. Please indicate which limit(s) of indemnity you require quotations for:

☐ 1 million ☐ 2 million ☐ 3 million ☐ 4 million ☐ 5 million ______ Other

I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever 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 the Underwriters as soon as practicable. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the policy 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.

FOR AND ON BEHALF OF ______

Name of Insured

SIGNATURE ______ Dated ______

NAME OF PROPOSER ______ Position ______

(IN BLOCK CAPITALS)

PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE APPROPRIATE QUESTION NUMBER.

©Marketform, September 2006

ADDENDUM 1 - ASSISTED CONCEPTION

1. If an Assisted Conception unit is maintained, please give a full 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)

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

YES NO

ADDENDUM 2 - CLINICAL RESEARCH

1. Please state for whom Clinical Research Projects are undertaken e.g. Pharmaceutical and other Manufacturers, Charities, Research Foundations.

2. Do you receive a full indemnity from your Principals?

YES NO

3. Do all volunteers sign an Informed Consent Form?

YES NO

4. If Double Blind studies are undertaken are volunteers made fully aware of this? YES NO

5. Do any trials involve any female volunteers of child-bearing age? YES NO

If 'YES' please provide full details:

6. Please state the Annual Income or Turnover:

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

8. 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:

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

Transplant	Human Embryo Research
Surgery	Artificial Organ
Obstetrics	Genetic Engineering

YES NO

If 'YES' please attach full details.

Please provide a copy of your Volunteer Informed Consent Form and any indemnity referred to in question 2 above.

ADDENDUM 3 - HEALTH & FITNESS CENTRES

1. Please state the approximate percentage of your income within the following categories:

Gym / Exercise %

Diet / Nutrition %

Sunbeds / Solarium %

Hairdressing %

Beauty Therapy %

Electrolysis %

Ear Piercing %

Other (please specify):

2. Please state the number and type of Complimentary Therapists

PLEASE ENCLOSE A COPY OF ANY OR ALL QUESTIONNAIRES THAT CLIENTS MUST COMPLETE PRIOR TO TREATMENT. IF THERE IS NONE STATE "NONE".

ADDENDUM 4 - INDUSTRIAL/OCCUPATIONAL HEALTH

1. Is your work solely "in-house" i.e. limited to other divisions or companies with common ownership to yourselves?

YES NO

If 'NO' please give full details of other companies for whom work is undertaken:

2. Please give full details of any outpatient or other medical facilities made available to staff:

3. Is health screening made available? YES NO

IF 'YES' PLEASE COMPLETE THE FOLLOWING ADDENDUM:

©Marketform, September 2006

ADDENDUM 5 - HEALTH SCREENING

1. Please give an approximate percentage breakdown of your patients between the following categories:

i) Insurance Medicals %
ii) General Fitness Assessment %
iii) Well Woman/Well Man %
iv) A.I.D.S. testing %
v) Other (please specify):

2. Do you have C.A.T./M.R.I. scanners or similar?

YES NO

If 'YES' please give details including date of purchase, details of any service contract or guarantee:

ADDENDUM 6 - MEDICAL PERSONNEL AGENCIES

1. What are the minimum acceptable qualifications and years of experience in respect of the following?
i) Nurses
ii) Midwives
iii) Other (please specify):

2. Are all staff vetted and references taken up?

YES NO

If 'NO' please give full details:

3. Do you ensure that all nurses and midwives supplied by you maintain membership of the R.C.N. or the R.C.M. or are otherwise insured for Medical Professional Liability?

YES NO

ADDENDUM 7 - PATHOLOGY LABORATORIES

1. Do you administer any pathology laboratories in medical establishments outside your ownership?

YES NO

If 'YES' please give full details:

2. What procedures are in place to ensure that results are promptly received by whom they were requested?

3. Please give a percentage breakdown by income between the following:

i) Human Pathology %
ii) Animal Pathology %
iii) Drug Testing %
iv) Other: e.g. Legionnaires/Salmonella etc %
(please specify and give full details):

Within (i) above please confirm what percentage, if any, of your income/turnover/gross receipts is derived from A.I.D.S. testing.

If none state "NONE": %

ADDENDUM 8 - REPATRIATION / AMBULANCE SERVICES

1. Please state the
i) Number of Ambulances in operation:

ii) Number of crew members per Ambulance:

iii) Minimum acceptable qualifications of crew members:

iv) Average number of routine trips to hospitals, nursing homes etc per annum:

v) Average number of emergency calls per annum:

2. Is an Air Ambulance repatriation service maintained?

YES NO

If 'YES' please state:
i) In which countries you anticipate operating:

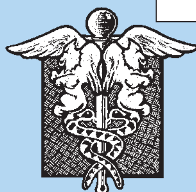
ii) The number of repatriations per annum:

3. Do you provide private Ambulance or First Aid at Public events?

YES NO

If 'YES' please give details of:
i) The type and size of event for which services are provided:

ii) The number of events per annum:



Marketform®

Syndicate 2468 at Lloyd's and / or Acting as agent for Syndicate 2468 at Lloyd's
Marketform Ltd (FSA Reg No. 310112) and Marketform Managing Agency Ltd
(FSA Reg No. 204971) are authorised and regulated by the Financial Services Authority

8 Lloyd's Avenue, London EC3N 3EL
Tel No. +44 (0)20 7488 7700 Fax No. +44 (0)20 7488 7800
INTERNET. http://www.marketform.com E-MAIL. info@marketform.com

©Marketform, September 2006