PROFESSIONAL
INSURANCE AGENTS LTD

Medical Malpractice Proposal Form

Return to:

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Medical Malpractice Proposal Form

Submit by Email | Print Form

Section 1 Contact Information

1.1)

Name of Business:			
Contact Name:		DOB:	
Date Established:		Mobile:	
Full Postal Address:		Tel:	
Post Code:		Fax:	
Website:		E-mail:	

1.2)

Tax status:

For profit: ☐ Not for profit: ☐ Public: ☐ Government Entity: ☐

Section 2 Business Information

2.1) Please confirm which Licensing/Registration Body(ies) you currently hold membership with:

2.2) Please provide your membership number:

2.3) Has membership or registration with any Licensing/Registration Body ever been refused, suspended, cancelled or had special conditions applied? ☐ Yes ☐ No

Section 3 Activities

3.1) Please provide full details of the activities you require cover for:

3.2) Please confirm number of staff as split below:

	EMPLOYED	NON-EMPLOYED		EMPLOYED	NON-EMPLOYED
PRINCIPALS/PARTNERS			PARAMEDICS		
CLERICAL/ADMIN STAFF			PARAMEDIC PRACTITIONERS		
GENERAL PRACTITIONERS			COMPLEMENTARY		
GENERAL SURGEONS			OTHER *(please specify below):*		
COSMETIC SURGEONS					
DENTISTS			OTHER *(please specify below):*		
REGISTERED NURSES					
NURSE PRACTITIONERS			OTHER *(please specify below):*		
NURSE ANAESTHETISTS					

Section 4 Turnover

4.1) Please provide your gross revenue earned and an estimate of the number of patients/clients treated, as requested below. These figures should relate only to work for which you are requesting cover under this policy:

	MOST RECENTLY COMPLETED FINANCIAL YEAR	1 YEAR PRIOR	2 YEARS PRIOR	ESTIMATE FOR CURRENT FINANCIAL YEAR
GROSS REVENUE	£	£	£	£
NUMBER OF PATIENTS / CLIENTS TREATED				

Section 5 Work Split

5.1) Do you have inpatient facilities? ☐ Yes ☐ No

If "YES", please give split as per below:

	NUMBER OF BEDS	LAST COMPLETED FINANCIAL YEAR	CURRENT FINANCIAL YEAR	FORTHCOMING FINANCIAL YEAR (ESTIMATE)
ADULT				
CHILD				
ELDERLY:				
OTHER: (please clarify below)				

5.2) Please provide a percentage split of patients as follows:

PHYSICAL DISABILITIES:	%
LEARNING DISABILITIES:	%
RESPITE CARE:	%
MENTAL HEALTH:	%
OTHER (please specify)	%
OTHER (please specify)	%

5.3) Please confirm the number of outpatient visits you had in the last year, the current year and the estimate for the forthcoming year:

LAST YEAR:	
CURRENT YEAR:	
FORTHCOMING YEAR:	

Section 6 Work Split

6.1) Please confirm roughly what percentage of your work relates to the following areas:

OUT OF HOURS WORK:	%
DENTAL SPECIALTY:	%
HOME VISITS:	%
MEDICAL REPATRIATION:	%
CRITICAL/EMERGENCY CARE:	%
PAEDIATRIC SPECIALTY:	%

6.2) Do you require that all non-employed medical staff hold their own Medical Malpractice Insurance? ☐ Yes ☐ No

Section 7

7.1) Please give full details of the following:

a) Which patient records are kept?

b) Where and how are they stored?

c) How long are they retained?

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

Section 8 Previous Insurance

8.1) Have you previously been insured for Medical Malpractice Insurance? ☐ Yes ☐ No

If "YES", please provide details:

	INSURER	LIMIT OF INDEMNITY	EXCESS:	PREMIUM:	DATE OF EXPIRY
YEAR:					
YEAR:					
YEAR:					

8.2) Has any insurer ever:

a) Declined a proposal or renewal for this practice or any partner/principle? ☐ Yes ☐ No

b) Required an increased premium or imposed special terms? ☐ Yes ☐ No

c) Cancelled an insurance? ☐ Yes ☐ No

If any of the above have been answered "YES", please provide full details in the additional information box below:

Section 9 Claims

9.1) Have any claims, whether successful or otherwise, ever been made against you? ☐ Yes ☐ No

9.2) Have any regulatory, disciplinary or criminal proceeds ever been made against you? *(Spent convictions do not need to be notified)* ☐ Yes ☐ No

9.3) After full enquiry, are you aware of any circumstances which could lead to a claim under this policy? ☐ Yes ☐ No

9.4) Does any person involved with the treatment or care of any patient suffer from any disability, transmittable disease i.e. Hepatitis, H.I.V. etc. or any other impediment which may affect the performance of their professional duties or place their patients/clients at risk? ☐ Yes ☐ No

If any of the above have been answered "YES", please provide full details in the additional information box below:

Section 10 Declaration

I / We declare that the statements and particulars in this proposal and submission are true and I / We have made a fair presentation of the risk, by disclosing all material matters which I / We know or ought to know or, failing that, by giving the Insurer sufficient information to put a prudent Insurer on notice that it needs to make further enquiries in order to reveal material circumstances. Furthermore, I / We will agree to inform Insurers of any material alterations to my / our circumstances that may occur before or after the completion of any contract of insurance offered to me/us by the Insurer.

Signature:

Full Name:

Date:

*** By signing this declaration, on behalf of our company and any applicable employees, we are also consenting to PIA sending relevant insurance information to us as part of their services. This consent can be withdrawn at any time by giving written notice to PIA.*

Please note that returning this proposal does not bind the Proposer or Underwriter to complete this insurance but does authorise 'Professional Insurance Agents Limited' to seek terms on my/our behalf from Insurers; including current Insurers.