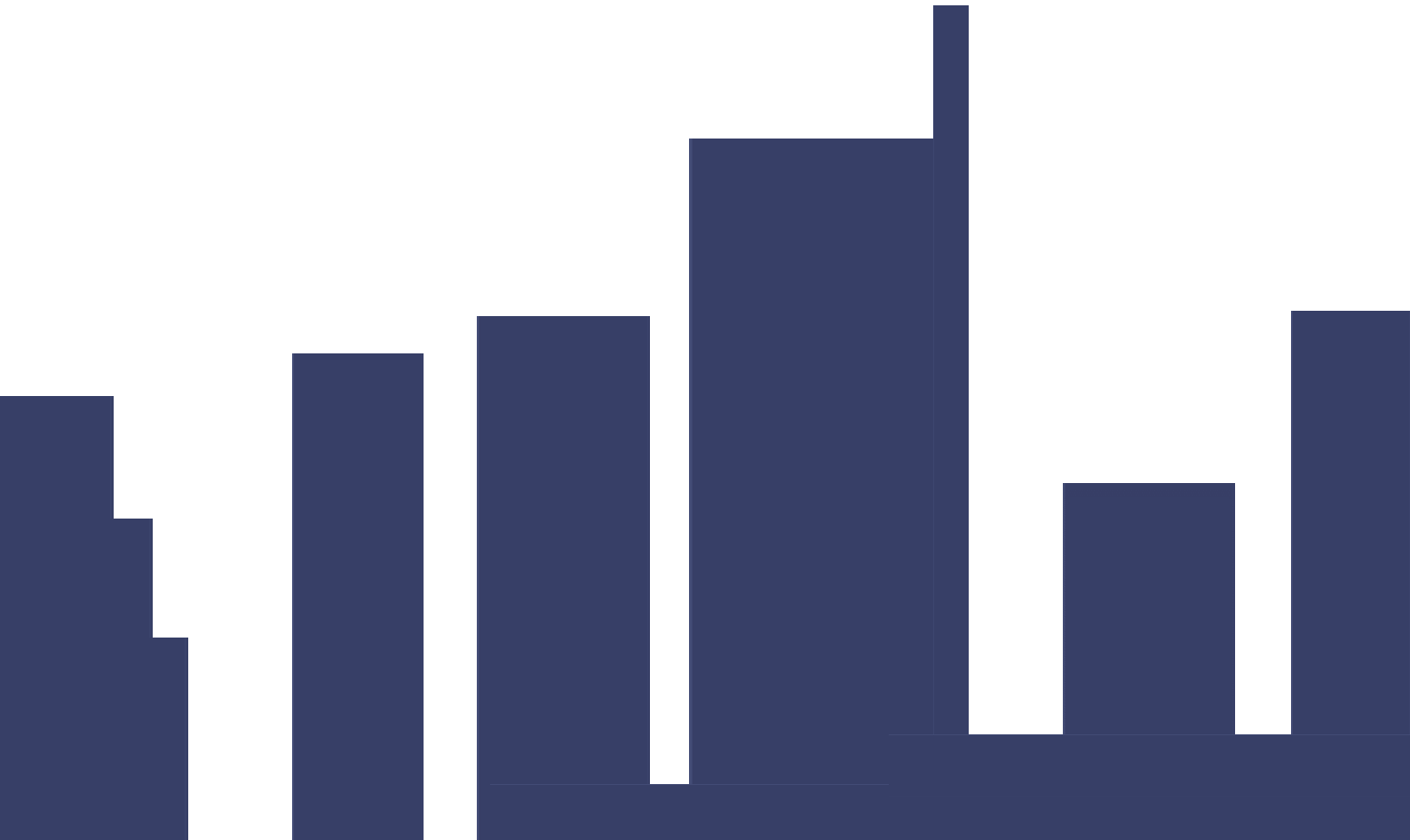
CHAMPION
professional risks

Surgeons Proposal Form

Medical Malpractice Insurance



INTRODUCTION

The purpose of this application form is for us to find out more about you. Completion of this application form does not oblige either you or us to enter into a contract of insurance.

Following a reasonable search you must provide us with all information which may be material to the cover we offer in a clear and accessible manner. Information is material if it would influence our decision whether to insure you, what cover we offer you or what premium we charge you. If you are in any doubt whether a fact or circumstance is material you should disclose it.

HOW TO COMPLETE THIS FORM

This form should be completed by the applicant who should make all the necessary enquiries to enable our questions to be answered

If you require extra space to answer the questions or provide any other material information, please use the additional information section at the back of the form. Once you have completed the form please return it directly to your insurance broker.

SECTION 1: PERSONAL DETAILS

1.1 Please provide the following details:

Title:	Full name:
Previous surname (if applicable):	
Gender:	Date of birth: DD / MM / YY
Personal address:	
	Postcode
Practice address:	
	Postcode:
Mobile telephone number:	Practice telephone number:
E-mail:	

SECTION 2: QUALIFICATIONS

2.1 Please state:

a) your primary medical qualification and the name of the university and the country where you studied:

Primary medical qualification:	
Name of the university:	
Country:	

b) the year in which you achieved your primary medical qualification:

c) what post graduate qualifications you have attained or any areas of specialist training or fellowships:

d) your GMC Registration Number:

e) the date of original GMC Registration: MM / YY

f) whether you are on any specialist register(s): ☐ Yes ☐ No

If yes, please state which one(s) and the registration date(s):

Specialist register	Registration:
	MM / YY
	MM / YY
	MM / YY

g) whether you are a member of any professional association(s): ☐ Yes ☐ No

If yes, please provide full details:

h) whether you participate in any national register(s) or interest group(s): ☐ Yes ☐ No

If yes, please provide full details:

SECTION 3: YOUR PRACTICE

3.1 Please provide a full breakdown by time spent of the medical and clinical professional services in which you are qualified and licensed to practice.

The total of all activities listed should equal 100%:

Anaesthesia	%	Orthopaedics:	%
Bariatrics:	%	Otorhinolaryngology:	%
Cardiology:	%	Paediatrics:	%
Cardiothoracic:	%	Pathology:	%
Dermatology:	%	Pharmacology:	%
Endocrinology:	%	Physiology:	%
Gastroenterology:	%	Plastic & reconstructive surgery:	%
General practice:	%	Psychiatry:	%
General surgery (*see below*):	%	Palliative Care:	%
Genetics:	%	Radiography / radiotherapy:	%
Gynaecology:	%	Radiology:	%
Haematology:	%	Rehabilitation:	%
Immunology:	%	Rheumatology:	%
Maxillofacial:	%	Urology:	%
Neurology:	%	Vascular:	%
Nuclear Medicine:	%	Other:	%
Oncology:	%	**Total:**	100%
Ophthalmology:	%		

If you are a general surgeon, or have indicated 'other', please provide full details:

3.2 Please state when you first commenced private practice: MM / YY

3.3 Please state whether you have ever ceased private practice for any period of time (e.g. sabbatical): ☐ Yes ☐ No

If yes, please explain why, including dates:

3.4 Please state whether you hold or have held any NHS consultant grade(s)/appointment(s): ☐ Yes ☐ No

If yes, please provide full details:

Hospital Trust	Dates of appointment:
	MM / YY
	MM / YY
	MM / YY
	MM / YY
	MM / YY

3.5 Please state your current practicing privileges:

Hospital Name	Private hospital group (e.g. BMI, Spire Nuffield, Ramsey, HCA, Circle)	Percentage of your overall time in Private Practice
		%
		%
		%
		%
		%
		%

3.6 Please state whether you perform any of the following roles:

MAC Chair ☐ Yes ☐ No

Member of a Medical Advisory Committee: ☐ Yes ☐ No

Clinical Supervisor: ☐ Yes ☐ No

Training Programme Director: ☐ Yes ☐ No

Examiner: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

If you have answered yes to any of the above, please provide full details, including the name of the hospital or organisation on whose behalf you performed these roles:

3.7 Please state your annual gross income (**before expenses**) in respect of the following:

	Last complete financial year	Estimate for the current financial year
Private practice, excluding medico legal work:		
Medico legal work (ex VAT):		
NHS work not covered by the NHS litigation authority. Please state below (e.g. choose and book, e-referral):		
Other:		

In respect of NHS work not covered by the NHSLA, please provide full details, including the hospitals where the work is undertaken. If 'other', please provide full details:

3.8 Please state the number of private patient episodes recorded in your appraisal, data or e-logbook for the past 12 months:

In-patient treatments:	patient episodes
Out-patient treatments:	patient episodes
New consultations:	patient episodes
Follow-up consultations:	patient episodes
Total:	patient episodes

3.9 Please state whether you undertake any paediatric work in private practice: ☐ Yes ☐ No

If yes, please state the percentage of your work in this field per annum %

3.10 Please state whether you undertake any work overseas: ☐ Yes ☐ No

If yes, please provide the following information in respect of each planned overseas trip during the next 12 months:

Country	Nature of medical and clinical professional services	Dates and duration of trip

3.11 Please state whether you are registered as a data controller under the Data Protection Act: ☐ Yes ☐ No

If you hold personally identifiable data on your own electronic system you must be registered with the Information Commissioners Office.

If you hold electronic data on your patients, please state whether you:

a) have anti virus software installed and enabled on all of your IT equipment, including desktops, laptops and servers (excluding database servers) and confirm that it is updated on a regular basis: ☐ Yes ☐ No

b) have firewalls installed on all external gateways: ☐ Yes ☐ No

c) take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or whether your outsourced service provider meets this requirement: ☐ Yes ☐ No

SECTION 4: OTHER ACTIVITIES

4.1 a) Please state whether you operate a limited liability company, limited liability partnership or similar joint venture: ☐ Yes ☐ No

If yes, please provide the company name and registration number:

Company name:	Registration No:
Company number:	Registration No:

b) If you have answered yes to a) above, please state whether this is solely for fiscal reasons: ☐ Yes ☐ No

4.2 a) Please state whether any other healthcare practitioner(s) provide services under the name of your limited liability company or limited liability partnership: ☐ Yes ☐ No

b) Please state whether you directly employ any staff (e.g. administrative, nursing): ☐ Yes ☐ No

If you have answered yes to a) or b) above, please provide full details:

Name	Role / job title	Employed/ self employed	Are they a Registered Healthcare Practitioner?	Do you require us to cover their activities?	If no, please state whether they purchase separate indemnity for these activities:

4.3 Please state whether you own or operate a hospital, nursing home, clinic, laboratory, day surgical centre or similar facility: ☐ Yes ☐ No

If yes, please provide full details, including any indemnity in place and the name of the indemnity provider:

4.4 Please state whether you undertake any type of work (paid or unpaid) for any sports club(s) or sports professional(s): ☐ Yes ☐ No

If yes, please provide full details, including the nature of the services provided, the type of sport, the level at which it is played and a copy of any contract in place:

4.5 Please state whether you treat any high profile patients whose income is generated by public or media appearances: ☐ Yes ☐ No

If yes, please provide full details:

4.6 Please state whether you provide any oncology services in private practice: ☐ Yes ☐ No

If yes, please state whether you are part of a multidisciplinary team: ☐ Yes ☐ No

If no, please explain why not:

4.7 Please state whether you are involved in any transplant work in private practice: ☐ Yes ☐ No

If yes, please give full details including the number of procedures undertaken per year:

Type of transplant	No. of procedures:

4.8 Please state whether you are involved in any pain management clinics in private practice: ☐ Yes ☐ No

If yes, please provide full details including the number of hours worked per month:

4.9 Please state whether you treat any trauma patients in private practice: ☐ Yes ☐ No

If yes, please give full details including the number of patients per year:

4.10 Please state whether you have peer support available to discuss unusual or complex cases which are at the limit of your expertise/experience: ☐ Yes ☐ No

If yes, please explain what you would do if presented with such a case:

4.11 Please state whether you are involved in any clinical trials for which you require cover: ☐ Yes ☐ No

If yes, please provide full details:

4.12 Please state whether you provide any remote prescribing or telemedicine services in private practice: ☐ Yes ☐ No

If yes, please provide full details including the number of hours per month:

4.13 Please state whether you participate in any activities that fall outside of your area of specialty for which you require cover (e.g. voluntary work, complementary medicine): ☐ Yes ☐ No

If yes, please provide full details:

4.14 Please state whether you plan to retire or cease practice in the UK during the next 5 years: ☐ Yes ☐ No

If yes, please provide the anticipated dates below and provide further details on the Additional Information page:

from Private Practice: MM / YY from the NHS: MM / YY from Medico Legal Work: MM / YY

4.15 If you have answered yes to 4.14 above, please state whether you intend to undertake any voluntary work after you retire ☐ Yes ☐ No

If yes, please provide full details:

SECTION 5: INDEMNITY HISTORY REQUIREMENTS

5.1 Please provide details of your current and previous indemnity arrangements covering your private practice and what you now require for this insurance:

	Retroactive date	Effective date	Limit	Deductible	Premium	Insurer
Previous:	MM / YY	MM / YY				
Previous:	MM / YY	MM / YY				
Previous:	MM / YY	MM / YY				
Current:	MM / YY	MM / YY				

	Retroactive date*	Effective date	Limit	Deductible
Now Required:	MM / YY	MM / YY		

*No cover is provided for actual or alleged acts, errors or omissions first occurring in whole or in part before the retroactive date

SECTION 6: CLAIMS EXPERIENCE

6.1 Please answer the following questions in relation to the NHS, Private Practice and any overseas work. Please consider all relevant information and if in doubt, refer to your broker. Regarding all of the types of insurance to which this application form relates.

After full enquiry:

a) have you **ever**:

i. been subject to any form of disciplinary action or investigation by a regulator, employer or private hospital where you hold or have held practicing privileges? ☐ Yes ☐ No

ii. been subject to any claim, complaint* or allegation of negligence (even if the outcome was in your favour)? ☐ Yes ☐ No

iii. been subject to any conditions or suspension to practice by any employer or private hospital where you hold or have held practicing privileges? ☐ Yes ☐ No

iv. been subject to any adverse findings, conditions, suspension or erasure by a regulator, registration body or equivalent? ☐ Yes ☐ No

v. had your practicing privileges suspended, reviewed or revoked? ☐ Yes ☐ No

b) are you aware of any incidents or circumstances which may lead to:

i. any claim, complaint* or allegation of negligence? ☐ Yes ☐ No

ii. disciplinary action or suspension from practice? ☐ Yes ☐ No

iii. conditions or restriction on your practice? ☐ Yes ☐ No

iv. removal of your name from a Professional or Regulatory Register or suspension of practicing privileges? ☐ Yes ☐ No

v. any investigation by a regulator, registration body or equivalent? ☐ Yes ☐ No

c) have you ever suffered a loss of data that has resulted in a privacy breach? ☐ Yes ☐ No

d) have you ever been subject to a Medical Defence Organisation Adverse Member Procedure? ☐ Yes ☐ No

e) have you ever had your membership of a Medical Defence Organisation or similar refused, cancelled or non-renewed? ☐ Yes ☐ No

f) has any insurer ever declined to insured you, imposed special terms, cancelled or declined to renew your insurance? ☐ Yes ☐ No

g) have you ever been convicted of any criminal offence or received a formal caution not spent under the Rehabilitation of Offenders Act 1974? ☐ Yes ☐ No

*Please note that "complaint" includes but is not limited to any verbal and written complaint and any expression of dissatisfaction.

If the answer to any of the above is 'yes' then please attach full details including an explanation of the background of events, all relevant dates, the status of the claims or circumstances, the maximum amount involved or claimed and any reserves or payments made.

Any matters disclosed in this application, including any application previously submitted to us, will not be covered unless otherwise specifically covered by endorsement.

SECTION 7: DECLARATION

I declare that:

- after full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;
- I will inform underwriters before cover incepts of any change to the information supplied by me; and
- I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Signed: _____ Full name: _____

Date: DD / MM / YY

ADDITIONAL INFORMATION:

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