challenge
INSURANCE BROKERS

MEDICAL INDEMNITY

INDIVIDUAL PRACTITIONERS
PRIVATE PRACTICE PROPOSAL FORM

PROPOSAL FORM

THIS PROPOSAL MUST BE SIGNED BY A PARTNER OR DIRECTOR OF THE BUSINESS. ALL QUESTIONS MUST BE ANSWERED AND ADDITIONAL INFORMATION PROVIDED WHEN REQUESTED TO ENABLE A QUOTATION TO BE GIVEN. THE COMPLETION AND SIGNATURE OF THIS PROPOSAL DOES NOT BIND THE PROPOSER OR THE COMPANY TO COMPLETE A CONTRACT OF INSURANCE.

PLEASE USE AN ADDITIONAL SHEET OF PAPER WHERE NECESSARY TO PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS.

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1. YOUR DETAILS

Name of the Insured Practitioner including Trading and Business Name
Date of commencement of the private practice / /

Home Address	Practice Address 1. 2. 3.
Is a practitioner/partner in full-time attendance at each practice address? Yes ☐ No ☐	
Home Tel	Work Tel
Email	Practice Website www.

Registration Body	Registration Number
Registration Date	Registration Type (Full/Limited/Provisional)

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2. ACADEMIC DETAILS

Country of Qualification	Year of Qualification
Medical School	
List Post Graduate Qualifications /Training	
List Membership of any Professional Organisation	
List HSE positions held over the last 10 years	
List Private Hospitals where you have admitting rights	

Staff Numbers (**excluding** Partners)

a) qualified	Full-time	Part-time
b) unqualified	Full-time	Part-time

Do you retain the services of any self-employed person? Yes ☐ No ☐

If 'Yes', please provide details

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3. MEDICAL ACTIVITIES

a. Please give details of **all** areas of medicine you are qualified and licensed to practice in and for which you require medical indemnity for

AREA	PLEASE TICK	AREA	PLEASE TICK
Anaesthetics	☐	Orthopaedic Surgery	☐
Cardiology	☐	Orthodontics	☐
Dermatology	☐	Paediatrics	☐
Dentistry	☐	Pathology	☐
Endocrinology	☐	Pharmacology	☐
Gastroenterology	☐	Physiology	☐
General Practice	☐	Plastic / Cosmetic Surgery	☐
General Surgery	☐	Psychiatry	☐
Genetics	☐	Palliative Care	☐
Haematology	☐	Radiography / Radiotherapy	☐
Gynaecology	☐	Radiology	☐
Immunology	☐	Rehabilitation	☐
Industrial Health	☐	Rheumatology	☐
Neurology	☐	Otorhinolaryngology	☐
Nuclear Medicine	☐	Oncology	☐
Nutrition	☐	Urology	☐
Ophthalmology	☐	Vascular Surgery	☐
OTHER – Please provide details	☐		

b. Please provide the % breakdown of your private work between the following

Type Of Practice	Employed %	Self- Employed %
Own Private Practice in a private hospital/clinic	%	%
Own Practice in HSE Hospital	%	%
Other (Please specify e.g. medic-legal)	%	%

c. Total Gross Annual Income from Private Practice	€
d. Total Gross Annual Income from Medico Legal	€
e. If you are a Surgeon, the average no. of Private surgeries per year	
f. Do you own or operate a Hospital, Nursing Home, Clinic, Laboratory, Day Surgical Centre or similar facility. If 'Yes', please provide details	Yes ☐ No ☐
g. Do you operate a Ltd Company or similar joint venture, If 'Yes', please provide the company name and number Is this for fiscals reasons? Yes ☐ No ☐ If 'Yes' provide details	Yes ☐ No ☐

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h. Do you undertake any other work for which you require indemnity?	Yes ☐ No ☐
i. Do you employ or engage with professional staff for whom you will be vicariously responsible? If 'Yes' provide details	Yes ☐ No ☐
j. Are you involved in clinical trials for which you require cover? If 'Yes' provide details	Yes ☐ No ☐
k. Do you undertake work on high profile people (defined as any person who is in the public eye or whose income is generated by public/media appearances? If 'Yes' provide details	Yes ☐ No ☐
l. Do you undertake work for any professional sports athletes? If 'Yes' provide details	Yes ☐ No ☐
m. Do you undertake any paediatric work? If 'Yes' provide details	Yes ☐ No ☐
n. Are you involved in any activities that require you to travel outside Ireland, United Kingdom, The Channel Islands or the Isle of Man? If 'Yes' provide details	Yes ☐ No ☐
o. Are you involved in any form of complementary or alternative medicine? If 'Yes' provide details	Yes ☐ No ☐
p. Do you plan to retire in the next 5 years? If 'Yes' provide details	Yes ☐ No ☐

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4. GENERAL QUESTIONS

a. Are you aware of any complaints, claims or circumstances that have been brought or threatened against you, or any incident which could lead to such a complaint, claim or circumstance?	Yes ☐ No ☐
b. Are you aware of any circumstances, which could lead to disciplinary action or suspension from practice?	Yes ☐ No ☐
c. Are you aware of any circumstance, which could lead to an investigation, suspension, the imposition of conditions or restrictions on your registration or license to practise, or your removal from a professional register of your license, by the relevant registration body?	Yes ☐ No ☐
d. Have you ever been subject to any form of disciplinary action?	Yes ☐ No ☐
e. Have you ever had conditions to practice, been suspended from practice or dismissed from practice?	Yes ☐ No ☐
f. Have you ever been subject to any form of investigation by a registration body or equivalent in another country?	Yes ☐ No ☐
g. Have you ever been subject of an adverse finding by a registration body or equivalent in another country?	Yes ☐ No ☐
h. Have you ever been refused registration or licence to practise or been erased from registration or has your license to practice been removed by a registration body?	Yes ☐ No ☐
i. Have you ever had any restrictions or conditions imposed on your registration or licence to practice by a registration body?	Yes ☐ No ☐
j. Have you ever been subject of a Medical Defence Organisation's adverse member procedure?	Yes ☐ No ☐
k. Has any Medical Defence Organisation ever declined to offer you membership, terminate membership or refused to renew membership?	Yes ☐ No ☐
l. Has any insurance indemnity provider ever declined to insure you, imposed special terms, cancelled or refused to renew your insurance?	Yes ☐ No ☐
m. Have you ever been convicted of a criminal offence or received a formal police caution?	Yes ☐ No ☐
n. If 'Yes' to any of the above, please provide full details on a separate sheet including the following - Date of Incident - A summary of the events, incl all relevant details such as your involvement - What action was taken to prevent a similar incident occurring in the future	

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5. INDEMNITY

a. Please confirm details of your current Medical Indemnity Provider?
Medical Defence Union ☐
Medical Protection Society ☐
Private Indemnity Insurance Company ☐
(Please name Insurance Company)

b. What is the renewal date of your existing cover? / /

c. Is your current cover on a Claims Made or Claims Occurring Basis?
Claims Made ☐
Claims Occurrence ☐
If Claims Made, please provide the Retroactive Date on your current cover
/ /

d. What Level of Indemnity do you require?

€1,300,000	☐	€2,600,000	☐
€6,500,000	☐	€13,000,000	☐
€	☐		

e. What Level Excess do you require (i.e. the first amount of a claim which you would pay)

€1,000	☐	€2,500	☐
€5,000	☐	€10,000	☐
€	☐	All excess' are each and every claim	

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6. DECLARATION

I/We declare that the statements and particulars in this Proposal are true and that I/we have not mis-stated or suppressed any material facts. I/We agree that this proposal together with any other information supplied by/me/us shall form the basis of any Contract of Insurance effected thereon. I/We undertake to inform Insurers or any material alteration to these facts occurring before completion of the Contract of Insurance.

Dated this day of 20

Signature of Partner

Name of Signatory (PLEASE PRINT) €

A COPY OF THIS COMPLETED PROPOSAL FORM SHOULD BE RETAINED BY YOU FOR YOUR OWN RECORDS.