



CHALLENGE MEDICAL INDEMNITY INSURANCE

**INDIVIDUAL PRACTITIONERS
PRIVATE PRACTICE PROPOSAL FORM**

Note: Please take time to complete this form comprehensively and include the most recent copy of your CV



THIS PROPOSAL, WHICH IS DESIGNED FOR CONSULTANTS ON THE IRISH MEDICAL COUNCIL'S SPECIALIST REGISTER, MUST BE SIGNED BY A CONSULTANT, 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.

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 <input type="checkbox"/> No <input type="checkbox"/>	
Home Tel	Work Tel
Email	Practice Website www.

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

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)

Qualified	Full-time	Part-time
Unqualified	Full-time	Part-time

Do you retain the services of any self-employed person? Yes No
If 'Yes', please provide details



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	<input type="checkbox"/>	Orthopaedic Surgery	<input type="checkbox"/>
Cardiology	<input type="checkbox"/>	Orthodontics	<input type="checkbox"/>
Dermatology	<input type="checkbox"/>	Paediatrics	<input type="checkbox"/>
Dentistry	<input type="checkbox"/>	Pathology	<input type="checkbox"/>
Endocrinology	<input type="checkbox"/>	Pharmacology	<input type="checkbox"/>
Gastroenterology	<input type="checkbox"/>	Physiology	<input type="checkbox"/>
General Practice	<input type="checkbox"/>	Plastic / Cosmetic Surgery	<input type="checkbox"/>
General Surgery	<input type="checkbox"/>	Psychiatry	<input type="checkbox"/>
Genetics	<input type="checkbox"/>	Palliative Care	<input type="checkbox"/>
Haematology	<input type="checkbox"/>	Radiography / Radiotherapy	<input type="checkbox"/>
Gynaecology	<input type="checkbox"/>	Radiology	<input type="checkbox"/>
Immunology	<input type="checkbox"/>	Rehabilitation	<input type="checkbox"/>
Industrial Health	<input type="checkbox"/>	Rheumatology	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	Otorhinolaryngology	<input type="checkbox"/>
Nuclear Medicine	<input type="checkbox"/>	Oncology	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	Urology	<input type="checkbox"/>
Ophthalmology	<input type="checkbox"/>	Vascular Surgery	<input type="checkbox"/>
Comments:			

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 <input type="checkbox"/> No <input type="checkbox"/>
g. Do you operate a Ltd Company or similar joint venture, If 'Yes', please provide the company name and number Is this for fiscal reasons? Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>
h. Do you undertake any other work for which you require indemnity?	Yes <input type="checkbox"/> No <input type="checkbox"/>
i. Do you employ or engage professional staff for whom you will be vicariously responsible? If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>
j. Are you involved in clinical trials for which you require cover? If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
l. Do you undertake work for any professional sports athletes? If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>
m. Do you undertake any paediatric work? If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
o. Are you involved in any form of complementary or alternative medicine? If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>
p. Do you plan to retire in the next 5 years? If 'Yes' provide details	Yes <input type="checkbox"/> No <input type="checkbox"/>



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 <input type="checkbox"/> No <input type="checkbox"/>
b. Are you aware of any circumstances, which could lead to disciplinary action or suspension from practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
d. Have you ever been subject to any form of disciplinary action?	Yes <input type="checkbox"/> No <input type="checkbox"/>
e. Have you ever had conditions to practice, been suspended from practice or dismissed from practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Have you ever been subject to any form of investigation by a registration body or equivalent in another country?	Yes <input type="checkbox"/> No <input type="checkbox"/>
g. Have you ever been subject of an adverse finding by a registration body or equivalent in another country?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
i. Have you ever had any restrictions or conditions imposed on your registration or licence to practice by a registration body?	Yes <input type="checkbox"/> No <input type="checkbox"/>
j. Have you ever been subject of a Medical Defence Organisation's adverse member procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>
k. Has any Medical Defence Organisation ever declined to offer you membership, terminate membership or refused to renew membership?	Yes <input type="checkbox"/> No <input type="checkbox"/>
l. Has any insurance indemnity provider ever declined to insure you, imposed special terms, cancelled or refused to renew your insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
m. Have you ever been convicted of a criminal offence or received a formal police caution?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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	



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
/ /

Limit of Indemnity

A Limit of Indemnity of €1,130,000, which takes cognisance of the Clinical Indemnity Scheme, will apply to each and every claim, subject to the Aggregate Limit.

The Aggregate Limit is the total indemnity amount provided in a 12 month policy period.

What Aggregate Limit of Indemnity do you require?

€1,130,000 <input type="checkbox"/> Aggregate Limit	€2,600,000 <input type="checkbox"/> Aggregate Limit
€6,500,000 <input type="checkbox"/> Aggregate Limit	€13,000,000 <input type="checkbox"/> Aggregate Limit
Other Aggregate Limit €	

What is your preferred Policy Excess? (i.e. the first amount of a claim which you would pay)

The policy excess is confirmed by insurers at quotation stage and may differ from your preferred option indicated below.

€2,500 <input type="checkbox"/>	€5,000 <input type="checkbox"/>
€7,500 <input type="checkbox"/>	€10,000 <input type="checkbox"/>
Other €	



DUTY OF DISCLOSURE

It is your responsibility to provide complete and accurate information for insurers when arranging an insurance policy, throughout the life of that policy, and when you are renewing it. It is important that you ensure that all information provided and all statements made on this proposal form and other documents are, to your knowledge and belief, complete and accurate. Failure to disclose any material information to your insurers could invalidate your insurance cover and could mean that all or part of a claim will not be paid. You may also experience difficulty obtaining cover elsewhere.

CLAIMS

It is essential that we are notified immediately of any claims or circumstances which could give rise to a claim. When you notify us, you must include all material facts concerning the claim. The policy wordings will describe in detail the procedures and conditions in connection with making a claim.

DECLARATION

I acknowledge and confirm that I have been provided with a copy of the Terms of Business of Challenge Insurance Brokers Ltd and that I have read through, understand and agree to these terms.

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

Signature of Consultant/Partner

Dated this _____ day of _____ 20

Name of Signatory (PLEASE PRINT)

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