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Healthcare Providers Application Form

This Application 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.

- The Application Form must be completed clearly using black or blue ink.
- Please complete in BLOCK CAPITALS
- It is the duty of the Applicant to disclose all material facts. For the purpose of this Application Form, a material fact shall be deemed to be one that would be likely to influence an underwriters judgement and acceptance of the Application Form.
- Each section of this Application Form must be completed in full. Incomplete, or unsigned, forms will not be accepted.
- It is the responsibility of the Applicant to notify any changes to any material facts.
- Once completed, please sign and date the Application Form and return it to:

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  Challenge House, 11 Burnell Square, Mayne River Way,
  Malahide Road, D17 VY04

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- Should there be insufficient room in the Application Form for details, please use the blank page at the back of the Application Form to record the answers, noting the appropriate question number.
- A copy of the Application Form should be retained for your own records.
- Upon acceptance of the Underwriter’s terms and conditions and payment of the premium, all information provided by the Applicant, together with the guidance notes, will be deemed to be incorporated in the contract between Underwriters and the Insured.

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THE SIGNING OF THIS APPLICATION FORM DOES NOT BIND THE APPLICANT OR UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE

Section 1. Applicant Details

This Application Form is designed exclusively for Medical Malpractice and Professional Indemnity Insurance.

Please complete the relevant addenda

1. Full Name of Company to be insured:

2. Date of Estalishment: D D / M M / Y Y Y Y

3. Registered Address

4. Postcode

5. Telephone No

6. Email Address

7. Website Address

8. Trading Names: (If different to above)

9. Other Trading Address:

10. Postcode

(If more trading addresses, please provide details on page 9)

Section 2. Professional Services

11. Company Characteristics (Please tick all appropriate boxes):

☐ For-Profit	☐ Not-For-Profit	☐ Government Entity	☐ Sole Partnership
☐ Limited Company	☐ Professional Association	☐ Partnership	☐ Franchise

☐ Other (please describe)

12. Please give a full description of the business activities for which cover is required:

13. Are there any major changes planned to the business in the forthcoming year? (Please give full details):

14. Please state the estimated number of patients seen per annun:

Inpatients | Outpatients

15. Please state: Total Number of Beds | Average Daily Occupancy

16. Where does the Applicant provide their services for the client? (The total must equal 100%)

Trading Address(es)	%	Hospital / Clinic	%	Prison	%
Medical University	%	Mobile Facility	%	Other (Please provide details below)	%

17. Please state the Gross Income generated from the Applicant's business. A copy of the accounts may be required.

	Last Financial Year (Actual)	Current Financial Year (Estimate)	Next Financial Year (Estimate)
UK and Ireland	€	€	€
Rest of World (Please state)	€	€	€

18. Is any work undertaken for the HSE where liability is covered under the Clinical Indemnity Scheme? ☐ Yes ☐ No

If Yes, please state or estimate the income generated for this work in the current financial year: ”

19. Does the Applicant sell or distribute any medical / pharmaceutical products and / or medical devices? ☐ Yes ☐ No
(Not including those used on or by patients throughout the course of their treatment)

20. Does the Applicant manufacture, alter, re-label, mix or blend products / devices in any way? ☐ Yes ☐ No

21. What was the annual turnover from sales or distribution of medical / pharmaceutical products and / or medical devices?

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22. W@æ [illegible]

Last Year ” [illegible] Current Year ” [illegible] Estimate for Next Year

Section 2. Professional Services

23. Is the Applicant registered with the HSE ☐ Yes ☐ No

24. If no, to Question 23, is the Applicant accredited / certified / licensed or registered with the appropriate regulatory body? (if Yes, by whom and specific to which operations?) ☐ Yes ☐ No

25. Has the Applicant ever been reviewed by HIQA, HSE or another body? ☐ Yes ☐ No

26. Has the Applicants' accreditation / certification / license or registration ever been revoked? ☐ Yes ☐ No

27. Please provide the approximate percentage of income derived from each of the following disciplines: (The total must equal 100%)

Discipline	%	Discipline	%
Allied Health Therapy	%	Hyperbaric Oxygen Therapy	%
Antenatal Clinic	%	Learning Disabilities	%
Assisted Conception	%	Medical Repatriation	%
Bio Banks	%	Nutritional / Dietetics	%
Casualty / Emergency	%	Obstetrics / Maternity	%
Clinical Trials	%	Opticians / Optometry	%
Correctional Health	%	Paediatrics	%
Counselling	%	Palliative Care	%
Day Surgery / Treatment	%	Paramedic / Ambulance Response	%
Dentistry	%	Pathology / Laboratory Services	%
Diagnostic & Medical Imaging	%	Pharmacy	%
Dialysis Services	%	Primary Care Services - GP Clinic	%
Domiciliary Services	%	Primary Care Services - Out of hours	%
Drug / Alcohol Dependency	%	Psychiatric	%
Elderly Care	%	Rehabilitation	%
Elective Cosmetic	%	Sports Medicine / Injury	%
Eye Surgery	%	Surgical Major	%
Gynaecology	%	Surgical Minor	%
Health & Fitness Centre	%	Termination of Pregnancy	%

Other (please specify below)

Section 3. Personnel Details

28. Please list the Full Time Equivalent (FTE, being 40 hours per week) of the personnel working for, or on behalf of, the Applicant.

Physicians	FTE Employed	FTE Self Employed	FTE Locums	**Other Medical Personnel**	FTE Employed	FTE Self Employed	FTE Locums
Non-procedural				Allied Health Professionals			
Specialisms				Attendant Carers			
Anaesthetics				Auxiliaries			
Gynaecology				Counsellors			
Obstetrics				Dentists			
Oncology				Laboratory Technicians			
Ophthalmology				Midwives			
Pathology				Nurses			
Psychiatry				Nurse Anaesthetists			
Radiology				Nurse Practitioners			
Sub-Specialisms / Surgery				Opticians / Optometrists			
Cardio-Thoracic				Paramedics			
General				Pathology Technicians			
Neurosurgery				Pharmacists			
Oral & Maxillofacial				Physiotherapist			
Otolaryngology				Psychologists			
Paediatrics				Radiographers			
Plastic & Reconstructive				**Non-Medical Personnel**			
Trauma & Orthopaedic				Directors / Partners / Principles			
Urology				Clerical / Administration			
Vascular				Other (Please specify on Page 9)			

29. Does the Applicant have in place a formal procedure for determining that:

- All doctors / surgeons have and maintain their own personal Professional Indemnity Insurance — Yes / No
- All other personnel are registered with the appropriate regulatory body? — Yes / No

30. In respect of all personnel do you provide in every case:

- An induction programme and employee hand book — Yes / No

31. Does the Applicant have formal procedures for ensuring that all personnel are provided with:

- Formal Training — Yes / No
- Supervision where necessary — Yes / No
- Continuing education for permanent members of personnel — Yes / No
- Appraisal / assessment for permanent members of personnel — Yes / No
- A confidentiality clause included in their contract / terms of service — Yes / No

Section 4. Risk Management

32. Does the Applicant adopt the following quality controls and risk management procedures?

	Yes	No
• Are patients provided with written material routinely as part of the consent procedure?	Yes	No
• Are patients consented to/informed by the practitioner who will be undertaking the procedure in every case?	Yes	No
• Are there protocols in place for the management of standard, frequently encountered conditions?	Yes	No
• Is there a system of on-going audit to ensure compliance with protocols?	Yes	No
• Is there a formal complaints procedure?	Yes	No
• Is there a system for the reporting and investigation of adverse / significant events?	Yes	No
• Is there a Health and Safety policy?	Yes	No
• Is there periodical Health and Safety training for personnel (e.g. manual handling)?	Yes	No
• Is there a protocol to ensure that good quality, contemporaneous medical records are made after all clinical contacts with patients (including telephone contacts)?	Yes	No
• Has the Applicant had a risk assessment carried out by an independent organisation within the last three years?	Yes	No
• Are there procedures in place for the checking and maintenance of clinical equipment or devices owned by the Applicant?	Yes	No
• Is leased clinical equipment or devices regularly checked and maintained by the supplier?	Yes	No
• Are there formal arrangements in place to follow up with referred patients where necessary?	Yes	No
• Are there formal arrangements in place for communicating with a referred patient's GP for each assessment of their treatment?	Yes	No

33. Does the Applicant provide facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that effective cross-infection methods are employed? Yes No

34. Does the Applicant have a protocol for needlestick injuries? Yes No

35. Does the Applicant maintain, and will continue to maintain, accurate descriptive records of all Medical Services provided for a period of at least seven (7) years form the date of treatment, and in the case of a minor, for at least seven (7) years after that minor attains majority? Yes No
(If "No" please provide full details on Page 9)

Section 5. Indemnity

36. Please provide details of the Applicant's current arrangements for Medical Malpractice and Professional Indemnity Insurance.

Insurance Company

Limits of Liability ”

Retroactive Date DD / MM / YYYY

Excess

Policy Period From DD / MM / YYYY

Premium

To DD / MM / YYYY

37. Requested Cover – Please indicate the level of indemnity that the Applicant requires.

[illegible]

[illegible]

38. Please state the date that the Applicant requires the insurance cover to commence DD / MM / YYYY

Section 6. Claims History and Punitive Measures

39. Has any application for this type of insurance cover ever been:

Declined? ☐ Yes ☐ No   Cancelled? ☐ Yes ☐ No   Required special terms? ☐ Yes ☐ No

If "Yes" to any of the above, please give full details in the space below.

Question	Yes	No
40. Have any claims been brought against the Applicant in the past 5 years?	☐	☐
41. Does the Applicant know of any incident which may give rise to a claim being made against the Applicant?	☐	☐
42. Have all of the above, in Question 40 and 41, been notified and accepted by previous Insurance Companies?	☐	☐
43. Has the Applicant or any of its Directors, Officers, Consultants or Employees ever been sanctioned or had disciplinary actions brought against them by any professional medical society, accreditation agency, or other governmental or non-governmental oversight entity?	☐	☐

If "Yes" to any of the above questions, please provide full details with complete information on all claims and circumstances, including full financial details. Please also provide dated copies of the loss runs from any previous insurers.

Section 7. Declaration

[illegible]
Ltd to release information, if applicable, and I/We confirm that we have read Section 8 – The Initial Disclosure Document.

FOR AND ON BEHALF OF

Name of Applicant

Signature

Dated D D / M M / Y Y Y Y

Name

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

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