Corvelia
underwriting

Medical Malpractice Insurance
Gynaecologist Proposal Form
(UK & Channel Islands)

NOTE TO PERSON COMPLETING THIS FORM: THIS PROPOSAL FORM IS AN IMPORTANT DOCUMENT AND TOGETHER WITH OTHER MATERIAL INFORMATION SUPPLIED IS BEING RELIED UPON BY UNDERWRITERS AS CONSTITUTING A FAIR PRESENTATION OF THE EXPOSURES BEING ASSESSED BY THEM. PLEASE ENSURE THAT ALL RESPONSES ARE ACCURATE, CLEAR AND CORRECT.

Please provide a copy of the PROPOSER's latest financial report and accounts with this Proposal form (or business plan financials if newly established).

Please use additional pages where necessary to provide complete responses.

"**PROPOSER**" means the firm, practice, company or other entity proposing for this insurance, and any subsidiaries and previous firms, practices, companies or other entities requiring coverage.

This Proposal form must be completed in ink, signed and dated by the Principal, Managing Director, Senior Partner, Compliance Officer or Insurance/Risk Manager of the **PROPOSER** (or any Partner or Director who has been with the **PROPOSER** for at least 3 years). All questions must be answered and where appropriate "Not Applicable" or "N/A" specified.

All facts material to the proposed insurance must be disclosed fully and truthfully and to the best of the **PROPOSER**'s knowledge and belief whether or not they are the subject of a specific question herein. **Under the Insurance Act 2015, a material matter is defined as one that would "influence the judgement of a prudent insurer in determining whether to take the risk and if so, on what terms."** In addition to the information contained in the Proposal form including all supporting documentation, if the **PROPOSER** is aware of any other information which it considers may alter, influence or prejudice the Underwriter's appraisal of the risk being proposed, this information must be disclosed in conjunction with this Proposal form.

This is a "Claims made" Insurance Proposal.
This insurance is underwritten on a "claims made" basis, which means that if a claim is made against the **PROPOSER** then the **PROPOSER MUST** have a current policy in force. Any claims brought against the **PROPOSER** after the expiry of the policy period (or any specific extended reporting period) will **NOT** be covered.

Coverholder at LLOYD'S

DATA PROTECTION SHORT FORM INFORMATION NOTICE

Your personal information notice

Who we are

We are the specialist underwriting agency authorised to underwrite professional liability business to the Health Industry under the Lloyd's Binding Authority on behalf of **Underwriters** as detailed below. This information notice is also relevant to the **Underwriters**.

The basics

We collect and use relevant information about you to provide you with your insurance cover or the insurance cover that benefits you and to meet our legal obligations.

This information includes details such as your name, address and contact details and any other information that we collect about you in connection with the insurance cover from which you benefit.

This information may include more sensitive details such as information about your health and any criminal convictions you may have.

In certain circumstances, we may need your consent to process certain categories of information about you (including sensitive details such as information about your health and any criminal convictions you may have). Where we need your consent, we will ask you for it separately. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may affect our ability to provide the insurance cover from which you benefit and may prevent us from providing cover for you or handling your claims.

The way insurance works means that your information may be shared with, and used by, a number of third parties in the insurance sector for example, insurers, agents or brokers, reinsurers, loss adjusters, sub-contractors, regulators, law enforcement agencies, fraud and crime prevention and detection agencies and compulsory insurance databases. We will only disclose your personal information in connection with the insurance cover that we provide and to the extent required or permitted by law.

Other people's details you provide to us

Where you provide us or your agent or broker with details about other people, you must provide this notice to them.

Want more details?

For more information about how we use your personal information please see our full privacy notice(s), which is/are available online on our website(s) or in other formats on request.

Contacting us and your rights

You have rights in relation to the information we hold about you, including the right to access your information. If you wish to exercise your rights, discuss how we use your information or request a copy of our full privacy notice(s), please contact us, or the agent or broker that arranged your insurance who will provide you with our contact details at:

<u>Corvelia</u>

Privacy notice accessible at: http://www.corvelia.com/privacy-policy/
Corvelia data protection contact: info@ambris.uk

<u>Underwriters</u>

<u>Arch Syndicate 2012</u> (managed by Arch Underwriting at Lloyd's Limited, 5th Floor, Plantation Place South, 60 Great Tower Street, London EC3R 5AZ)
Privacy notice accessible at: http://www.archcapgroup.com
Arch Privacy email address / data protection contact: ArchDPO@archcapservices.com

1.

Please advise personal information as follows:	
Full Name:	
Date of Birth:	Gender:
Contact Tel No:	Contact Email:
Home Address (Including Country):	
Relevant Medical Qualifications:	Medical School(s) Attended:
*Please provide the latest copy of Your Curriculum Vitae and attach it to the completed Proposal Form.	

2.

Please advise details of Your GMC Membership as follows:-		
GMC Registration Number:	Registration Type (e.g. Specialist, Full, Provisional):	
First Registration Date:	Last Re-Validation Date:	
Date You started in Private Practice:		
Have You had any breaks in clinical practice (of more than1 month) within the last 5 years?		YES/ NO
If YES, please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken during this time off:-		
Do You plan to retire in the next 5 years?		YES/ NO
If YES, please advise when:		
*Please provide a copy of Your Licence to Practice and attach it to this Proposal form.		

3.

Please disclose any other Medical Associations or Regulatory Bodies with which You hold a licence or membership including Your first date of concurrent membership:-	
Organisation:	**1st Membership Date:**

4.

Please advise as follows:	
Are **You** registered to practice in any other countries?	**YES / NO**
If YES, please provide details:-	
Do **You** undertake any surgical procedures outside of the UK?	**YES / NO**
If YES, please provide details:-	
Do **You** trade or work for a legal entity? (e.g. Partnership or Limited Company)	**YES / NO**
If YES, please advise the following:-	
Your Status (e.g. Employee, Partner):-	
Entity Name:-	
Entity Address:-	
Is the Entity covered under a separate Medical Malpractice/ Professional Indemnity Policy?	**YES / NO**
If NO, please advise whether cover is required hereunder:-	**YES* / NO**
If **YES**, please also provide details of the Entity's current Medical Malpractice/ Professional Indemnity Policy as below:-	

Insurer	Expiry Date	Limit	Excess	Retro-Active Date	Premium

* (If **YES,** a separate Corvelia Entity Proposal Form will need to be completed).

5.

Other Practitioners			
Do **You** (or the Entity detailed in question 4 if applicable) employ other Medical Practitioners that require Professional Liability cover hereunder? If **YES,** please provide CVs for each person where cover is required and advise:-			**YES/NO**
Name	**Number Of Hours Work / Week**	**Services Performed (e.g. Nurse Prescriber, Radiographer, RMO)**	
Do **You** have any responsibility for the activities of any theatre staff, anaesthetists or other surgeons that are not detailed in (iv) above?:-			**YES/NO**
If YES, please provide details below:-			

6.

Please detail the main premises that You perform gynaecological work including details of ownership:-			
Practice or Hospital (Premises)	Address	Details Of Premises Owners (e.g. NHS Trust)	Average Working Hours Practiced at This Address/ Week

7.

Please provide details of Your split of activities as follows as a proportion of revenue earned in the last full financial year:-	
Private Practice Directly Treating Private Patients	%
Private Practice Treating Private Patients Via A Contract With A Private Company (e.g. Spire, Nuffield, Ramsey etc.)	%
NHS Outsourced Work For Which **You** Require Indemnity	%
NHS Practice With The Benefit Of NHS Indemnity (not covered hereunder)	%
Medico-Legal Reports	%
Other (please state)	%
TOTAL	100%

When is Your Financial Year End? :-

Please provide the following information for each of the last 3 full financial years and the current financial year in which You are applying for indemnity. This should exclude NHS work which has the benefit of NHS Indemnity:-

	Last Full Financial Year Ended:-	**Previous Full Financial Year (1 Year ago)**	**Previous Full Financial Year (2 Years ago)**	**Estimate of Current Outstanding Financial Year**
Gross Revenue (Sterling):	£	£	£	£

8.

Clinical Activities:-	
Please provide details of Your gynaecological procedures and consultations performed in the last 12 months as follows:-	
Total Number of Procedures	
Total Number of Consultations	
Procedures Performed Under Local Anaesthetic	%
Procedures Performed Under General Anaesthetic	%
TOTAL	**100%**
Please provide the % of Your surgical procedures performed under general anaesthetic as follows:-	
Procedures Undertaken Up to 1 Hour	%
Procedures Undertaken > 1 to 4 Hours	%
Procedures Undertaken > 4 to 8 Hours	%
Procedures Undertaken > 8 Hours	%
TOTAL	**100%**
Please provide details of the age distribution of Your patient list:-	
16 Years or below	%
17 – 25 Years	%
26 – 40 Years	%
41 – 60 Years	%
61 + Years	%
TOTAL	**100%**

9.

Please provide details of Your procedure types undertaken during the last full financial year:-		
Surgical Procedure		**Number of Procedures Performed**
Tension Free Vaginal Tape Oburator		
Stress Incontinence Sling Operation		
Pelvic Organ Prolapse Surgery		
Myomectomy		
Oophorectomy		
Myosure		
Cervical Cauterization		
Labiaplasty	Cosmetic	
	Medical	
Vaginoplasty	Cosmetic	
	Medical	
Hymenoplasty	Cosmetic	
	Medical	
Perineorraphy	Cosmetic	
	Medical	
Hysterectomy	Open	
	Laparoscopic	
Pill Abortion		
Surgical Abortion (Please specify types performed e.g. Manual Vacuum Aspiration, Prostaglandin injection etc.)		
Other (Please Specify)		
TOTAL		

Please provide the % of **Your** procedures performed that are oncology -specific:-	
Do **You** currently, or intend to, perform any obstetrics work? If **YES**, please provide details:-	**YES/NO**
Please provide full details of any issues that **You** have faced regarding defective medical products used e.g. Mesh products or other:-	
Did **You** provide any activities and disciplines in the last 6 years that are not currently undertaken or are **You** planning any new activities for the next 12 months:-	**YES/NO**
If **YES**, please provide details:-	

10.

Are You currently insured for Medical Professional Liability Insurance?	YES/NO
If **YES** please advise as follows:-	

Insurer	Claims Made or Occurrence Policy	Expiry Date	Limit	Excess	Retro-Active Date	Premium

If **YES**, please also advise:-	
Does **Your** current policy have a Discovery Period or Extended Reporting Period in the event that the policy is not renewed?	**YES/NO**
If **YES**, how long is this Discovery Period or Extended Reporting Period?	
Have **You** ever been refused similar insurance, or had any policy cancelled or voided at any time?	**YES/NO**
If **YES**, please provide full details:-	

11.

Please Advise:-	
Has membership or registration with a licensing/ registration body as listed in question 2 or question 3 ever been refused, suspended, withdrawn, or had conditions imposed?	**YES / NO**
If **YES**, please provide details:-	
Have **You** ever had practice related issues in connection with drug and/or alcohol abuse, sexual addiction or mental illness?	**YES / NO**
If **YES**, please provide details:-	
Have **You** ever been diagnosed with, or treated for, a chronic physical illness and/or disability?	**YES/NO**
If **YES**, please provide details:-	

Please advise:	
Are **You** aware of any physical illness, mental illness and/or disability that may affect **Your** medical practice now or in the future?	**YES / NO**
Do **You** maintain up to date case notes and medical records including accurate records of all procedures undertaken for each patient and observatory records of post-procedural recovery?	**YES / NO**
If **NO**, please advise under what circumstances this would not happen:-	
Do **You** ensure that all treatment to patients under the age of consent is only undertaken with the consent of the relevant parent or legal guardian?	**YES / NO**
If **NO**, please provide full details of when this does not happen:-	
Do **You** ensure that in all reasonable instances an informed consent is obtained from the patient in writing* before any surgical procedure is undertaken?	**YES / NO**
Does this consent include a preclinical consultation discussing the procedure to be performed and the risks inherent to the procedure?	**YES / NO**
If **NO** to either of the above, please advise when such consent would not be obtained:-	
Are **You** renowned for providing medical services to high profile clients in the entertainment, sports or business industries?	**YES / NO**
If **YES,** please provide more details:-	

***Please provide a copy of Your standard consent form and/ or any disclaimer documentation and attach it to this completed proposal form**

12.

CLAIMS HISTORY:-	
Medical Practitioner Insurance for Surgeons is underwritten on a 'claims made' basis and the Insurer will exclude any claim and/or circumstance which may give rise to a claim, which is known by YOU prior to the inception date of the policy. **Please provide answers to the following questions.**	
Have any professional negligence or medical malpractice claims ever been made against **You** whether successful or otherwise?	**YES/NO**
Have any claims ever been made against **You** relating to any loss or damage caused or materially contributed by a proven defectively manufactured medicine or medical product?	**YES/NO**
Have any claims for dishonesty ever been made against **You** whether successful or otherwise?	**YES/NO**
Have any regulatory, disciplinary, or criminal proceedings (including judicial enquiries) ever been made or undertaken against **You**?	**YES / NO**
Have **You** ever had a document relating to **Your** medical activities unintentionally destroyed, damaged, lost or mislaid?	**YES / NO**
Have any libel or slander claims ever been made against **You** whether successful or otherwise?	**YES / NO**
Have any infringement of copyright claims ever been made against **You** whether successful or otherwise?	**YES / NO**
Have any breach of confidentiality claims ever been made against **You** whether successful or otherwise?	**YES / NO**
Have any sexual harassment and/or abuse claims ever been made against **You** whether successful or otherwise?	**YES / NO**
After full enquiry are **You** aware of any circumstances relating to the questions above which may give rise to a potential claim or request for indemnity under this Individual Practitioner policy?	**YES / NO**
If the answer to any of the above is **YES (for any of the last 6 years)**, please provide full details in the table below:-	

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Claims Information as per Question 12.

Date Of Loss	Date Notified	Claimant Name	Description Of Claim	Excess	Settlement Value	Outstanding Reserve	Legal Fees Paid	Legal Fee Reserve	Status of Claim

***Please provide an up-to-date full claims experience/ Letter of Good Standing from Your previous Insurer(s)/ defence body for the past 6 years**

DECLARATION:-
You declare that the above answers, statements, particulars and additional information are true to the very best of **Your** knowledge and belief and are a fair presentation of **Your** risk. After full enquiry, **You** also confirm that **You** have disclosed all information and material facts that may alter or influence the Underwriters' judgement of the risk, or affect their assessment of the exposures they are covering under the policy.
Please ensure that the following forms are attached to this proposal form:
▪ **The latest copy of Your Curriculum Vitae**
▪ **A copy of Your Licence to Practice**
▪ **A copy of Your standard Patient Consent Form**
▪ **Copies of the Curriculum Vitae and Licence to Practice of any other individual practitioners requiring cover hereunder**
▪ **An up-to-date full claims experience/ Letter Of Good Standing from Your previous Insurer(s)/ defence body for the past 6 years**

Your Signature _____

Date _____

Position _____

Name in capital letters (Printed) _____

Following the commencement of this contract of insurance, **You** must advise Underwriters as soon as practicable, and as a matter of urgency, of any changes to the original information provided to Underwriters when the Application Form was originally submitted to Underwriters. Such information must include anything which it considers may alter, influence the judgement of or prejudice the Underwriter's appraisal of the risk being covered hereunder. Failure to disclose such new or amended information may prejudice **Your** position in the event of notification of a Claim under this policy.