



5. i) Where did you graduate?

ii) In what year?

iii) With what degree, diploma or designation?

Please give details of any additional or post graduate qualifications and attach copy of relevant certificate.

  
  


6. In what capacity are you qualified or licensed to practise?

- |                        |                          |                         |                          |
|------------------------|--------------------------|-------------------------|--------------------------|
| Audiologist            | <input type="checkbox"/> | Osteopath               | <input type="checkbox"/> |
| Chiroprapist           | <input type="checkbox"/> | Paramedic               | <input type="checkbox"/> |
| Chiropractor           | <input type="checkbox"/> | Perfusionist            | <input type="checkbox"/> |
| Dietician              | <input type="checkbox"/> | Pharmacist              | <input type="checkbox"/> |
| First Aider            | <input type="checkbox"/> | Physiotherapist         | <input type="checkbox"/> |
| Medical Lab technician | <input type="checkbox"/> | Podiatrist              | <input type="checkbox"/> |
| Midwife                | <input type="checkbox"/> | Prosthetist / Orthotist | <input type="checkbox"/> |
| Nurse                  | <input type="checkbox"/> | Radiographer            | <input type="checkbox"/> |
| Nurse Aesthetician     | <input type="checkbox"/> | Sonographer             | <input type="checkbox"/> |
| Nurse Anaesthetist     | <input type="checkbox"/> | Speech Therapist        | <input type="checkbox"/> |
| Occupational Therapist | <input type="checkbox"/> | Surgical                | <input type="checkbox"/> |
| Optometrist/Optician   | <input type="checkbox"/> |                         |                          |

Other (Please specify):

  


If you practise as a Midwife:

a) Please state the number of:

i) Emergency non hospital births you attended in the last 12 months:

ii) Routine home births you attended in the last 12 months:

b) Please give full details of any back-up hospital arrangements:

7. Please give full details of what patient records are kept, where & how they are stored and for how long they are retained:

  
  


Please note it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

8. Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed.

	EMPLOYED	SELF-EMPLOYED
The Proposer's Private Practice	<input type="text"/>	<input type="text"/>
Public Sector Hospitals / Homes	<input type="text"/>	<input type="text"/>
Private Surgical Hospitals / Homes	<input type="text"/>	<input type="text"/>
Private Non-Surgical Homes	<input type="text"/>	<input type="text"/>
Patients' Homes	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Total	<input type="text"/>	<input type="text"/>

If you are an employee, please state the name of the employing authority or the name of the private hospital or company for which you work.

9. WHAT IS YOUR TOTAL GROSS ANNUAL INCOME (excluding income from the sale of goods) FOR THE WORK YOU ARE PROPOSING TO INSURE? (If new business please state estimated income for the forthcoming 12 months)

10. Do you own (wholly or in part), operate or administer any hospital, nursing home or any other medical establishment?

YES  NO

**IF THE ANSWER IS 'YES' AN ADDITIONAL PROPOSAL FORM WILL HAVE TO BE COMPLETED BEFORE QUOTATIONS CAN BE GIVEN**

11. Please state the number of staff and give details of the capacity in which they practise:

  
  


12. i) Does the Proposer or any member of staff involved in the treatment or care of patients suffer from any disability, transmittable diseases i.e. Hepatitis, H.I.V. etc., or other impediment which may affect the performance of his or her professional duties or place patients at risk?

YES  NO

If 'YES' what procedures are in place?

  
  


ii) Has the Proposer or any member of staff involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries?

YES  NO

If 'YES' please give full details:

13. i) Are you a member of any professional organisation, or registered with any self regulating body? YES  NO

If 'YES' please state which and period of membership / registration:

ii) Has membership or registration with such organisation / body ever been suspended, withdrawn, amended or declined or had conditions attached? YES  NO

14. If you are an employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance?

YES  NO

If 'YES' please give full details:

15. Have you ever been Insured for Medical Professional Liability? YES  NO

If 'YES' please state:  
 i) The name of the Underwriter/s:

ii) The Insurance period/s:

iii) The limits of liability provided:

iv) Has any application for this type of Insurance cover ever been:

a) declined? YES  NO

b) cancelled? YES  NO

c) required special terms? YES  NO

If 'YES' please give full details:

### PREVIOUS CLAIMS HISTORY

16. i) List all claims made against the Proposer during the last 10 years, including any made against the Proposer even if cover was not previously purchased. **IF NONE, PLEASE STATE "NONE"**:

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the allegations and details of Claimant

ii) List all circumstances / complaints which may give rise to a claim being made against the Proposer, even if cover was not previously purchased. **IF NONE, PLEASE STATE "NONE"**:

Date of Circumstance / Complaint:	Details including nature of the Complaint and details of the Complainant

17. i) Have all of the above in question 16 been notified to your previous Underwriters: YES  NO

ii) Have all of the above been accepted by your previous Underwriters? YES  NO

18. Please indicate which limit(s) of indemnity you require quotations for:

1/4 million     1/2 million     1 million     2 million     Other (please specify)

I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as practicable. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.

NAME OF PROPOSER   
 (IN BLOCK CAPITALS)

SIGNATURE  Dated

**PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS  
FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE  
APPROPRIATE QUESTION NUMBER.**

Empty space for recording answers to questions.



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