Medical Professional Liability Proposal Form for Medical Establishments Excluding Australia & USA)

Guidance Notes and Important Notices

These NOTICES apply to this Proposal and any attached Addenda

These guidance notes explain about the duties of disclosure required in completing this Proposal and some of the more important aspects of the insurance contract. It is important that the answers are full and accurate. However, signing this Proposal does not bind the Proposer or the Underwriters to complete a contract of insurance. This Proposal uses certain terms defined within the corresponding policy wording and which should be read in conjunction with this Proposal.

Important Notices

Please note that for the purposes of this insurance policy the Underwriters consider that where any Insured has received either an oral or written communication from or on behalf of a patient and/or a request by or on behalf of a patient for copies of medical records, then the Insured shall be deemed to have been aware of a Claim. The Underwriters will not be liable for any such Claim that has not been reported.

Proposal

This **Proposal** must be typed or completed in ink and signed and dated by the Proposer. This **Proposal** is made by the Proposer to the Underwriters to enter into a contract of insurance and the Proposer <u>MUST</u> have the requisite authority on behalf of the **Insured** to complete and sign it. Every question must be answered accurately and fully. NONE or NOT APPLICABLE should be entered if any questions do not relate to the **Insured**. A quotation by the Underwriters may be refused or delayed if any answers are incomplete. If you are unsure about any question or if you need any assistance in completing this **Proposal**, please contact us or your Insurance Advisor. The **Proposal** and the insurance policy shall be considered as one sole document.

In the event of any conflict between the **Proposal** and the policy, the policy shall prevail.

"Claims Made" and Prior Claims

This is a proposal for a "Claims made" policy. A "Claims made" policy only provides cover in respect of Claims made against the Insured and notified to Underwriters during the Policy Period and /or any discovery period. The Underwriters shall not be liable for any Claim or Defence Costs that the Insured knew about or reasonably could have foreseen or discovered prior to the Policy Period. For example, where any Insured has received either an oral or written communication from or on behalf of a patient and/or a request by or on behalf of a patient for copies of medical records, the Insured will be deemed to have been aware of a Claim. In addition, the Underwriters shall not be liable for any Claim or Defence Costs arising from any circumstance, occurrence, fact, matter or Claim notified to any insurer and/or medical defence organisation prior to the Policy Period.

Material Statements

The Underwriters will rely upon the material statements and information supplied in the **Proposal** and therefore it is important that:

a) all Medical Services for which cover is required and

b) every matter which is known or ought reasonably to be known by the **Insured** and that a reasonable person in the circumstances could be expected to identify as relevant and/or material to the risk being insured

are disclosed in the **Proposal** before this policy is entered into and at any renewal, extension, variation or reinstatement of the policy.

In the event of any material changes during the **Policy Period**, such as expansion, addition of new services or locations, merger, sale or take-over, it is important that these material changes are notified to the Underwriters immediately in writing, as these changes will affect the coverage provided by this policy.

In the event of unintentional non-disclosure, the Underwriters may at their absolute discretion refuse to cover additional exposure to that which was disclosed; or charge a reasonable additional premium; or avoid the contract.

In the event of intentional or fraudulent failure to comply with the duty of disclosure, or fraudulent misrepresentation to the Underwriters, the Underwriters may avoid the contract.

Acceptance of Terms

Upon acceptance of the Underwriters' terms and conditions, it is important that the premium is paid in accordance with the payment terms, as non-payment of the premium will result in the policy being declared void from its inception date.

Waived Recourse Rights and Rights of Subrogation

This policy includes a provision that will exclude or limit Underwriters' liability in respect of loss where you are a party to an agreement that excludes or limits your rights to recover damages from a person in respect of that loss. Underwriters refer you specifically to clause 4.4 of the policy terms.

Legal Notices

EU Residents: The parties making this contract are free to choose the law applicable to this contract. Unless the Proposer indicates otherwise in the **Proposal**, the contract shall be subject to the law of the country of domicile of the **Insured**. In any event, the Proposer is advised that the Underwriters are subject to regulation by Lloyd's of London and ultimately by the Financial Services Authority in the United Kingdom.

Non-EU Residents: If the Proposer has requested and the Underwriters have accepted that this contract be subject to the laws and jurisdiction of the country of domicile of the **Insured**, then if any of the terms of the policy are in conflict with any applicable statute, the policy terms shall be deemed amended, in order to comply with the minimum provisions of such law.

This **Proposal** is <u>not</u> intended for use by residents of Australia or the United States of America or of any territories which are subject to the laws of the United States of America.

The MPLC is an underwriting intermediary licensed in Gibraltar by the Financial Services Commission under licence number FSC00659B. The MPLC has notified the FSC of its intention to provide cross border services in accordance with the requirements of the EU Insurance Mediation Directive. The MPLC's insurances underwritten by certain underwriters at Lloyd's.

Complaints

The MPLC aims to provide a first class professional service to its customers. Should you have any questions, concerns or complaints about your policy or the handling of a **Claim** you should, in the first instance, contact your broker.

Alternatively, you may wish to contact The MPLC by writing to:

Managing Director
The Medical Professional Liability Company Limited,
Regal House,
Queensway,
P.O. Box 1446,
Gibraltar.

In the event that you are unable to resolve the situation you may, in certain circumstances, contact the Complaints Department at Lloyd's.

Address: Complaints Department, Lloyd's, One Lime Street, London EC3M 7HA; Tel No: 020 7327 5693; Fax No: 020 7327 5225; E-mail: Complaints@Lloyds.com

Finally, in the event that the Complaints Department is unable to resolve your complaint, it may be possible for you to refer it to the Financial Ombudsman Service (FOS) or other local dispute resolution body. Further details will be provided at the appropriate stage of the complaints process.

Broker/Insurance Advisor's details:	

A. Corporate Information Section

Please provide the following information about the Insured as a corporate entity.

1. i)	The Insured 's full n	ame:	
ii) T	he Insured 's trading t	name (if different):	
iii) H	ow long have you bee	en trading under the abo	ve name?
2. Yes	Have you ever carrie	ed out Medical Services	under a different name?
If "Y	ES", then give full de	tails here:	
3.i)	Who is the Insured ?	's ultimate owner or hol	ding company?
ii) or in			or Canadian origin with any ownership te owner or holding company:
Nam	e	Origin (USA/CAN)	% Holding
			0/0
			0/0
			0/0
iii) H parer	ow long has your curi nt/owner?	ent operation been mar	naged or owned by the present
iv) Pl Addı	_	e Insured 's Registered (Office:
Post	code:	Country:	
Telep	phone:		
Fax:			
www Ema			

v) Ple	ease give details of the Insured 's Trading Address(es):
Address	:
Post coc	de: Country:
Telepho	ne:
Fax:	
www.	
Email:	
	separate Proposal must be completed for each additional location or company sured, if any.
	ny of your activities involve a joint venture with any other company, partnership, idual or other professional grouping?
Yes	No
vii) Will	your activities involve new or incoming partners becoming involved in your tivities during the next 12 months?
Yes	No
If the an	nswer is YES to either of questions vi) and vii) then please give details here:
possessi	respect of Medical Services at the addresses specified above, are you in on of the relevant licences and/or registrations from the applicable regulatory as required by law?
Yes	No
If "NO"	' then give full details here:
,	Which associations, professional bodies or self-regulatory organisations is the Insured a member of or registered with?
	Has membership or registration with any such bodies or organisations in the past ever been suspended or withdrawn, had conditions imposed on it or an application for it declined?
Yes	No
If "YES"	" then give full details here:

ii) What is your total gross feea) for the last complete financial	ncome, turnover or gross receipts: year?
b) and an estimate for the curren	t financial year?
6. What percentage of fundir	g is derived from the following?
a) Government or public funds	0/0
b) Private funding	0/0
c) Charitable donations	0/0
Total	100 %
Total 100 % 7. i) Are there any discussed or proposed changes in your activities or any major developments likely to occur within the next 12 months? Yes No If "YES" then give full details here: ii) Has the exposure relating to this Proposal changed materially over the last five years (E.g. have there been material changes in the number of beds, procedures carried out, or doctors employed or other significant changes in the risk)? Yes No If "YES" then please provide full details in a separate table or spreadsheet. 8. Do you have any subsidiary companies for which cover is also required? Yes No If "YES" then give full details in a separate Proposal .	

5. i) When does your financial year end?

B. Medical Services Section

N.B. In respect of Questions 9. i), 10 and 11, if you are unable to provide the required breakdown easily, please provide a similar breakdown on a separate sheet using the categories appropriate to your establishment for which information is readily available.

Does the	Insured have any	in-patient	facilities?
Ves	No		

If "NO", then continue from Question 11 onwards.

9. i) Total beds now and average daily occupancy over last 12 months:

	Number	Average Daily Occupancy
Acute Care beds		0/0
General beds		0/0
Psychiatric beds		0/0
Rehabilitation beds		0/0
Geriatric beds		0/0
Long stay beds		0/0
Hospice beds		0/0
Bassinets, cribs and cots		0/0
I.C.U./ I.T.U. beds		0/0
N.I.C.U.		0/0
Total		$^{0}\!/_{0}$

- ii) Total number of infant deliveries per annum (Please complete Addendum D if any):
- iii) Total number of in-patients:

Last complete financial year

Current financial year estimate

iv) Proportion of in-patients coming from the following territories (last complete financial year):

USA %

Canada %

10.	Number	of IN-PATIENTS	ADMITTED	during the last 1	2 months:

Dental/Maxillofacial	%
Drug/Alcohol Dependency	%
Elective Cosmetic Surgery	%
Elective T.O.P.	%
Gender Reassignment	%
Geriatric	%
Keyhole Surgery	%
(Please complete Addendum C).	
Infectious Diseases	%
Obstetrics	%
Organ Transplant	%
Paediatric	%
Psychiatric	%
Other minor surgery	%
Other intermediate surgery	%
Other major surgery	%
Other: (Please specify)	%
	%
	%
Total	100 %

11. Please provide information about procedures performed at any out-patient clinic(s) NOT included in the above information or set out in a separate Proposal. Specify approximate number of patients treated and percentage of Gross Fee Income, Turnover, Gross Receipts (if applicable) in the last complete financial year:

	Number of	Turnover/	% of
	patients per	gross	outpatient
	annum	receipts	turnover
		1	
Accident and Emerge	ncy		0/0
(Please complete Add	endum A if any).		
Antenatal Clinic			%
Dental/Maxillofacial			0/0
Elective Cosmetic			0/0
Elective T.O.P.			0/0
Fertility Treatment			%
(Please complete Add	endum B if any).		
HIV/HEP (inc. Coun	• /		0/0
Laser Eye Surgery			0/0
Nutrition / Diet / Slimming			0/0
S.T.D.	C		%
Sports Injury			%
Well Man / Well Woman			0/0
Other Medical - give breakdown and details here:			
			0/0
			0/0
			0/0
			0/0
Total			100 %

12. Do you have an i) - C.T./M.R.I. scann	ny of the following facilities: ers or similar?
Yes	No
If "YES" then is ther	e a maintenance agreement with a third party?
ii) Medical teaching f	facilities?
Yes	No
iii) Nursing teaching t	facilities?
Yes	No
iv) Pathology laborate	ories?
Yes	No
v) Owned ambulance	es?
Yes	No
vi) Owned or operate	d air ambulances?
Yes	No
13.i) Do you have a products?	blood bank that procures, tests and distributes blood or blood
Yes	No
ii) Average number o	of units of blood and blood products used per month in last 12 months:
iii) Is 100% of above Cross?	obtained from National Blood Transfusion Service or National Red
Yes	No
If "NO" then give fu	ll details here:
according to the curren	Il blood or blood products for transmittable or infectious diseases at guidelines from your National Blood Transfusion Services, or equivalent licensing body prior to use?
Yes	No
v) Provide full d	etails of types of testing carried out:

C. Medical Services-Personnel Section

The MPLC's policy primarily provides medical professional liability insurance cover for the **Insured** in respect of **Claims** being made against it in respect of work performed by any person who is, has been or may become, during the **Policy Period**, a principal, partner, director, employee or volunteer of the **Insured**, including part time employees, students, locums, agency nurses and other temporary employees. It does **NOT** automatically cover **Independent Professional Practitioners** who work or provide services on or out of your premises or who may expose you to potential **Claims UNLESS** you specifically request Underwriters to do so in Question 15 below.

14. Total numbers of persons involved in the following capacities:

--- Full and Independent
--- part-time Professional
--- employees Practitioners

Doctors

Residential Medical Officers
Psychiatrists
Other Non Procedural Physicians
Cosmetic Surgeons
Orthopaedic Surgeons
Other Surgeons
Anaesthetists
Obstetricians / Gynaecologists

Other Medical Personnel

Midwives
Nurses – Day
Nurses – Night
Pharmacists
Paramedics
Supplementary Professionals, including radiographers, technicians, etc.
Complementary Professionals

Non-Medical Personnel

Directors / Partners / Principals Clerical / Administration Other Personnel (Please provide a breakdown)

TOTAL

15. Do you require cover for **Independent Professional Practitioners** who work or provide services on or out of your premises or who may expose you to potential **Claims**?

Yes No

If yes, then please provide a schedule listing all individuals for whom <u>additional</u> coverage is required, stating their full name, address, date of birth, occupation, and qualifications. **Please note that any coverage will only be in respect of work performed for and on**

behalf of the Insured, and no coverage will be available for work performed by these individuals for any other party.

ALL professional prac specialisations issued	curate records of and ensure that throughout the Policy Period titioners hold valid licences to practise in their respective by the relevant lawfully established and recognised licensing rritories specified in the answer to Questions 3 (iv) and (v)?
Yes	No
ii) Do you take up refe	erences in respect of ALL your professional practitioners?
Yes	No
If the answer is "NO"	'to either of the above, then please provide full details here:
iii) During the last 10 y disciplinary proceeding	rears have any professional practitioners ever been subject to gs for misconduct in professional matters?
Yes	No
	rears, have any professional practitioners or staff members been d for arson, drugs, fraud, malicious damage, theft or injury to any
Yes	No
v) Has any professiona held by a court, tribuna have been negligent?	al practitioner presently employed or engaged by you ever been al or similar body to have committed an act of fraud or held to
Yes	No
vi) Has any professiona statutory obligations, b	al practitioner or staff been found guilty of a breach of any by-laws or regulations?
Yes	No
If the answer to any of	questions iii) to vi) is "YES" then please provide full details here:

vii) Do you keep accurate records of and ensure that throughout the **Policy Period** all **Independent Professional Practitioners** are members of a medical defence organisation or similar scheme, club, association or arrangement from which such practitioners benefit from insurance or indemnity or have the benefit of another form of compensation or payment or insurance in respect of their activities and potential exposure to **Claims**?

Yes No

If "NO", then please refer back to Question 15 and provide a schedule listing any individuals for whom coverage is required.

D. General Services and Records Section

17.i) Do you provide current guidelines and employed?	facilities for the sterilisation of instruments in accordance with do you ensure that effective cross-infection control methods are
Yes	No
ii) Do you have a prot	ocol for needlestick injuries?
Yes	No
If "NO" to any of Que here:	estion 17, then provide details of what arrangements are in place
18.i) Do you maintain all Medical Services a	a and will you continue to maintain accurate descriptive records of and equipment used in procedures?
Yes	No
If "NO" then provide	full details in the space below.
	ill you continue to retain the records referred to above for at least ten e of treatment and, in the case of a minor, for at least ten (10) years majority?
Yes	No
If "NO" then provide	full details in the space below.
iii) Do you retain and vindefinitely?	will you continue to retain and preserve obstetric records
Yes	No
If "NO" then provide	full details in the space below.
iv) Do you maintain a r for copies of medical r	record of all requests (whether written or oral) on behalf of patients ecords?
Yes	No

v) Would all medical records referred to above be made available for inspection and use by Underwriters or their appointed representatives together with such oral or written information, assistance, signed statements, evidence or depositions as Underwriters may require in the investigation or defence of any Claim without charge to Underwriters?
Yes No
If the answer is "NO" to any of Question 18, then provide full details here:
19. Do you promote or publish any advice or information or give any diagnosis or treatment of any type over the Internet or via any computer or any electronic system accessible outside your premises?
Yes No
If "YES" then give full details here:

If "NO" then provide full details in the space below.

E. Public Liability Insurance Section

No

No

(ii) workers' compensation insurance?

Yes

Yes

Do you require coverage for public liability Claims (including coverage for the provision of food and drink)? Yes No If "YES", then complete this section, if not please complete Question 24 onwards. 20.i) Are all buildings owned or used by you in a good state of repair and regularly maintained? Yes No ii) Are the following regularly checked, serviced and repaired by fully qualified engineers? Air Conditioning Units Electricity Generators (Including any Emergency backup generators) Escalators Heating Systems and Boilers Hoists Incinerators Lifts Water Tanks Sprinkler System iii) a) Give details of premises functions or facilities which you subcontract here: b) Do you ensure that all subcontractors carry their own insurance? Yes No c) Does such insurance include: (i) public liability insurance?

(iii) do	you require copies of these policies or inspect copies of these policies?
Yes	No
21.i) D	the premises comply with current fire precaution and prevention requirements?
Yes	No
ii) Are s	raff instructed in and kept regularly appraised on fire and emergency procedures?
Yes	No
iii) Is the	re an emergency electrical system?
Yes	No
	swer is "NO" to any of Questions 20 or 21 above, then please provide full details in wing supplementary information box:
22.i) At current §	e there facilities for safe collection, storage and disposal, in accordance with guidelines or legislation of:
a) Sharp	s?
Yes	No
b) Dress	ings, clinical and surgical waste, etc.?
Yes	No
	ou ensure that the following are safely disposed of, in accordance with current selegislation:
a) blood	and blood products?
Yes	No
b) all ot	ner waste?
Yes	No
If you he here:	we answered "NO" to any of the questions in 22 above then provide full details
	you require cover for liability arising from Products ? (NB. The standard policy liability arising from Products other than Food and Drink). No

If "YES" then complete Addendum E.

F.--Previous Insurance History and Circumstances Please refer to your insurance broker if you are in any doubt as to what is being asked in this section.

24. Who are your present medical professional liability and (if applicable) public liability insurers?
Medical Professional Liability:
Public Liability:
25.i) Has prior coverage been on a CLAIMS MADE BASIS?
Medical Professional Liability
Yes No
Public Liability
Yes No
If "YES", what are the retroactive dates?
Medical Professional Liability:
Public Liability:
If "NO", then provide a copy of your current insurance policy.
NB. The MPLC's cover for both Medical Professional Liability and Public Liability sections of our policy is on a Claims made basis.
ii) Has insurance cover been maintained in force continuously since the retroactive date stated in Question 25. i) above?
Yes No
If "NO" then please provide full details here:
iii) What are the indemnity limits of your current policy?
Medical Professional Liability:
Public Liability:

iv) What	is the self ins	ured Excess?				
Medical Professional Liability:						
Public Liabilit	Public Liability:					
v) What is the	e expiry date?					
Medical Profe	essional Liabi	lity:				
Public Liabilit	y:					
vi) Please give	full details o	f all similar insura	ance held during	the past 5 year	s (below):	
Policy Year	CM LO	Retroactive Date	Limit of Indemnity Any One Clai m	Limit of Indemnity Any One Year	Deductible Self Insured Excess	
	-					
	-					
	- -					
Note: CM LO						
26.i) Has any	application fo	or these types of in	isurance coverage	ever:		
a) been return	ned or decline	ed?				
Yes	No)				
b) been cance	elled or had ro	enewal refused?				
Yes	No					
c) had special	terms impos	sed?				
Yes	NO)				
ii) During the circumstances	last 10 years and/or repor	have you ever ha t a Claim in a time	nd any insurer allely manner in acc	ege a failure to pordance with po	notify licy conditions?	
Yes	No)				

iii) During the last 10 ye were aware, for exampl which subsequently res	ears have you notified circumstances to any insurer of which you e, an allegation of negligence, error, omission, misleading conduculted in a Claim ?
Yes	No
iv) During the last 10 ye faith by you or your pre or director?	ears has any previous insurer alleged a breach of utmost good edecessors in business or any present or former principal, partner
Yes	No
aware of any matter, oc	estigation, are any of the principals, partners, directors or staff currence or circumstance, which may result in any Claim against rs in business or any present or former principal, partner, director ner?
Yes	No
aware of any accounts of	estigation, are any of the principals, partners, directors or staff overdue for payment where there is reason to believe that the tisfied with the professional services rendered?
Yes	No
If the answer to any of the	ne above is "YES" then give details here:

G. Insurance Requirements

27.i) Indicate which options you require for Limit of Indemnity and self-insured **Excess**.

Limit of Indemnity:

Cumpoparrupit

NB. The Limits of Indemnity include Defence Costs and are in the aggregate for the Policy Period

Currency unit	
1,000,000	9,000,000
2,000,000	10,000,000
3,000,000	12,000,000
4,000,000	14,000,000
5,000,000	16,000,000
6,000,000	18,000,000
7,000,000	20,000,000
e_000_000	Otla a m /mla a a a

8,000,000 Other: (please specify)

Excess:

N B. The Excess is the amount you bear each Claim, including Defence Costs, which must remain at your own risk and uninsured.

Currency unit

5,000 75,000 10,000 75,000 100,000

25,000 Other: (please specify)

50,000

- ii) As regards third party **Claims**. The MPLC's standard policy only covers **Claims** made against you in the jurisdiction of the country where the premises are, from which you carry on your business. If you wish other jurisdictions to be included, state which ones here and why:
- iii) The MPLC's policy can be extended to provide the following enhancements of cover. Your broker can give you further details. Note that sub-limits may apply and for certain Proposals, these options may not all be available.
- a) Breach of Confidentiality
- b) Dishonesty of Employees
- c) Loss of Documents
- d) Errors and omissions (not resulting in bodily injury)
- e) Libel and Slander
- f) Reinstatement of policy limit in the event of a Claim

Standard Basis RTC Basis

RTC (Round the Clock) Basis means that the reinstated limit will only apply after your **Excess** layer insurers have all paid their full aggregate limits, and the additional premium will be reduced accordingly.

If you choose RTC basis then indicate below any limits of insurance you are seeking in **Excess** of the limits sought under The MPLC's insurance. You must also advise your **Excess** insurers that you have an RTC basis of reinstatement and advise us in the event that the **Excess** limits finally obtained are other than as anticipated below.

Excess limits sought and/or obtained:

H. Previous Claims history

28. You must list here or on a separate sheet all **Claims** made against you during the last TEN (10) years, whether insured or not. The amount of the **Claim** should include **Defence Costs**. Include both Medical Professional Liability and Public Liability **Claims**. Underwriters consider a **Claim** to have been made where an **Insured** has received either an oral or written communication from or on behalf of a patient or any third party or a request by or on behalf of a patient for copies of medical records. **Include all incidents which are reasonably likely to give rise to a Claim, even if no Claim has been made. If there is insufficient space, please provide a separate schedule with the above information for each Claim**. **IF NONE**, **PLEASE STATE NONE**.

Date of	Date of	Amount	Amount	Amount	Details – including	Notified
Incident	Claim	Claimed	Paid	O/s	nature of the	to and
					allegations	accepted
					and details	by
					of Claimant	previous
						Insurers
						or
						Medical
						Defence
						Organisa
						tion

Please use the additional information sheet to record any other previous **Claims**, noting the appropriate question number. If you have written "NO" in the final column above, then please provide an explanation (please refer to the guidance notes regarding prior **Claims**).

I. -- Declaration Section

29. Please provide here any additional information that may be material to the Underwriters, e.g., details of additional **Medical Services** for which coverage is required – types of management systems and procedures followed by you, risk management, or **Claims** management systems. Please attach a copy of your latest annual report and any other materials, which describe the nature of your business. Your duty of disclosure and the answers given by you to the specific questions in the **Proposal** form will be treated by the Underwriters as applying to each person or entity seeking cover, including each principal, partner or director.

I/We declare and warrant that I/we have read and understood the guidance notes and important notices and that after full examination, all statements and particulars contained in the Proposal and Addenda are true and that no information whatsoever has been withheld that 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 immediately. 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 cancelling 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.

FOR AND ON BEHALF OF
Full Name of the Insured (IN BLOCK CAPITALS PLEASE)
SIGNATURE
SIGNATURE
DATE
NAME OF PROPOSER
(IN BLOCK CAPITALS PLEASE)
POSITION HELD

Addendum A – Emergency Care

- 1. Which one of the following best describes the level of accident and emergency services provided by you? (Please tick appropriate box):
- i) Full comprehensive emergency care services (including specialists) and a physician experienced in emergency services 24 hours a day.
- ii) Emergency care services 24 hours a day including a physician experienced in emergency services able to consult with specialists within 30 minutes.
- iii) Emergency care services 24 hours a day and a physician available for emergency care area within 30 minutes, able to consult with specialists or arrange transfer to another facility.
- iv) Render life saving first aid and reasonable care in determining if an emergency exists. Appropriate referrals to the nearest organisations that are capable of providing care.

If none of the above applies then provide full details here:

Addendum B – Fertility Treatment

2. Yes	Do you perform genetic manipulations? No
3.	Are you involved with genetic selection?
Yes	No
4. Yes	Are any changes to the above activities anticipated in the next 12 months?
5. Yes	Do you operate a sperm bank? No
If the	e answer is "YES" to any of Questions 2 to 5 then please give full details here
6.	Do you screen donors for HIV or AIDS?
Yes	No
7. recon	Is all donor semen cryopreserved and quarantined in line with current nmendations?
Yes	No
8.	What are your gross revenues and fees from the provision of such services?
Last o	complete financial year:
Curre	ent financial year estimate:

1. Describe the fertility services you provide in the space below and attach any brochures or publications you issue:

Addendum C – Keyhole Surgery

1. this to	Do all surgeons performing keyhole surgery procedures have specific training in echnology?
Yes	No
2.	Is such training a requirement of the Insured ?
Yes	No
3.	Is the equipment tested prior to each use?
Yes	No
4. Yes	Is the procedure explained to the patient and his/her consent obtained? No
5.	Are policies and procedures in place to ensure the following are carried out::
i) Yes	Explaining the nature of procedures to patients and obtaining their consent? No
ii)	Vetting of patients for suitability for the procedure?
Yes	No
iii)	Post operative care and guidance?
Yes	No

Addendum D – Maternity / Obstetrics

- 1. Which one of the following best describes the level of maternity and obstetric services provided by the **Insured**?
- i) Full obstetric services, including the ability to perform a caesarean section, for patients not considered to be at high risk of complications during labour or delivery.
- ii) Capable of managing high risk deliveries and caring for neonates who are small or moderately ill. Neonates may or may not have a special care nursery.
- iii) Comprehensive services to all patients, including the ability of the unit to function as a regional referral centre for high risk pregnancies and very small or seriously ill neonates. Services include a separate intensive care unit and may also provide stabilisation and transport services for neonates from the referring hospital.

If none of the above adequately reflect the level of services you provide then give full details here:

Addendum E - Products

Please provide details of the **Products** that you produce or supply.

1.	Types of Product (Please specify)	Annual value of goods produced or supplied	Percentage of total
			0/0
			0/0
			0/0
			0/0
			0/0
			0/0
			0/0
			0/0
			0/0
			0/0
			%
Yes If "Y	No /ES" then give details here:		
3. Yes	Are any of your Products in No	ncorporated into other manufacturers' p	products?
If "Y	YES" then give details here:		
4. Yes	Do other institutions or deal	lers alter, fit or maintain your Products	s?
If "Y	'ES" then are recourse rights wa	aived against them?	
5. into	Are any of your Products many automobile, watercraft, as	nade specially or knowingly by you to b ircraft or spacecraft or nuclear facility?	e incorporated
Yes	No		
If "Y	YES" then give details here:		

6. Do you give a guarantee with an	ny of your Products ?			
Yes No				
If "YES" then give details here:				
7. Are any of your Products sold States of America, Canada or other terri	or otherwise supplied ditories subject to the laws	irectly by you to the United of these countries?		
IF "YES" then provide details here:				
Product Description	Country	Annual Value of Products supplied		
NB. In no case will the policy include pharmaceutical Products or where you waive rights of recourse against a manufacturer or supplier.				
Check List				
Please complete the following checklist to ensure that all relevant additional information has been provided.				
1. Please attach a copy of your current financial report with the Proposal .				
	c 11: 11 :			

- 2. Is a separate **Proposal** provided for additional locations, if any? (Refer to Question 3 v in Section A).
- 3. Is a schedule of **Independent Professional Practitioners** attached? (Refer to Questions15 and 16).
- 4. Have all relevant Addenda been completed? (Refer to Addenda A to E).
- 5. Have full **Claims** details been provided? (Refer to Question 28).
- 6. Has any relevant additional information been provided? (For example Risk Management procedures)
- 7. Has the **Proposal** been signed and dated?
- 8. Have you retained a copy for your records?

Additional Information

Please use this space to record the answers to any questions for which you require additional space, noting the appropriate question number