Proposal Form Medical Malpractice Professional Indemnity

vero liability insurance limited

IMPORTANT: Duty Of Disclosure

This proposal form is to be completed by the Applicant or an Authorised Officer of the Applicant. The information provided to Vero Liability in this proposal form will be the basis of any contract of insurance entered into.

There are serious consequences if you fail to tell us information which is material to our decision to issue, renew, or alter this policy, or the terms on which we did any of these things.

You must disclose to Vero Liability Insurance Limited all information which is material to it in deciding whether to issue insurance cover to you, and if so on what terms and/or premium. This includes but is not limited to any circumstances or conduct which might lead to a claim being made against you. This may also include information which is additional to the questions that we have asked. The duty to disclose material information occurs prior to the commencement of cover, prior to each renewal or whenever the policy is varied. This means that prior to renewal or any policy variations, as well as advising of new information you may also need to advise us of any alterations to the facts previously notified.

Failing to disclose material information may result in your policy being avoided. This means that your policy would be deemed to have never existed and no claims would be payable.

If there is insufficient space to provide full information in this proposal document, please attach additional sheets. **WHEN IN DOUBT DISCLOSE.**

Claims Made Policy

This is a proposal form for a Claims Made policy. The policy will only respond to claims and/or circumstances which are first made known to the Insured and notified to Vero Liability Insurance Limited during the policy period. The policy will not provide cover for:

- Events that occurred prior to the retroactive date of the policy (if specified).
- Claims made after the expiry of the policy period (or extended reporting period if available) even though the act giving rise to the claim may have occurred during the policy period.
- Claims notified or arising out of facts or circumstances notified under any previous policy or noted on the current proposal form or any previous proposal form.
- Claims made, threatened or intimated prior to the commencement of the policy period.
- Claims arising from circumstances known to the Insured at the commencement of the policy period as having the potential to give rise to a claim.

Applicant Details

Name of applicant including trading names, names of subsidiaries and any other parties to be insured

Address

Website Address

Email Address | Contact Person

Phone Number | Broker / Agent

Business Details

Type of Facility

- ☐ Private Hospital
- ☐ Public Hospital
- ☐ Clinic
- ☐ Hospice
- ☐ Group Practice
- ☐ Nursing Home
- ☐ Laboratory
- ☐ Pharmacy
- ☐ Retirement Village
- ☐ Rehabilitation Centre
- ☐ Other (please specify)

Nature of Practice Entity:

☐ Joint Venture ☐ For Profit ☐ Non-Profit/charitable ☐ Limited Liability Company ☐ Limited Partnership

[Please furnish copies of any brochures, or other documentation which may assist Vero Liability in gaining a complete appreciation of your business/profession.]

Please provide gross fees or income (including fees paid to subcontractors)	This year	$
	Next year	$

When was the business established?

Has the name of the business ever changed? Yes ☐ ▶ No ☐

▶ If Yes, please advise

Has any other business amalgamated or merged with you?	Yes ☐	No ☐
▶ If Yes, please advise		
Have you purchased another business?	Yes ☐	No ☐
▶ If Yes, please advise		
Please list the professional bodies or associations to which the Applicant belongs:		
Do you sell any products? ▶ If Yes, please advise	Yes ☐	No ☐
Are any of your products and/or services subject to any legislation governed by the Financial Markets Authority? (refer www.fma.govt.nz)	Yes ☐	No ☐
▶ If Yes, please advise what steps you have taken to ensure you/your business is compliant with the legislation.		

Staff Details

Please advise number of employees in each category

Dentists	Pharmacists	
Doctors (including locum doctors)	Physiotherapists	
Healthcare assistant/health workers	Principals, partners or directors	
Interns	Surgeons	
Laboratory Technicians	X-Ray Technicians	
Midwives	Other registered professionals	
Non-technical administrative staff	Other skilled & technical employees	
Nurses - Enrolled	Other (specify):	
Nurses - Registered	Total	0

Have any of the Doctors, Nurses or Staff ever been subject to disciplinary proceedings, or reprimand by any Court or professional association as a result of their professional activities?	Yes ☐	No ☐
▶ If Yes, please advise details.		

Activities Details

Are you ISO 9001 certified?	Yes ☐	No ☐
▶ If Yes, when was this achieved and for which activities?		
Do you have any of the following:		
(a) Intensive care unit (ICU)?	Yes ☐	No ☐
(b) Accident and emergency department	Yes ☐	No ☐
(c) Outpatients department?	Yes ☐	No ☐
(d) Medical teaching facility?	Yes ☐	No ☐
(e) Pathology facility?	Yes ☐	No ☐
(f) Blood banking facility?	Yes ☐	No ☐
What is the total number of beds?		
What is the average annual occupancy rate?		
What is the total number of bassinets?		
What is the total number of patients annually?	Inpatients	Outpatients

Please advise the approximate percentage of the following types of professional healthcare services:			
Audiology	%	Oncology	%
Aged care/assisted living	%	Ophthalmology (including LASIK and laser)	%
Clinical trials	%	Paediatrics	%
Communicable diseases	%	Pathology	%
Dentistry	%	Plastic surgery (elective cosmetic)	%
Dermatology	%	Plastic surgery (reconstructive)	%
Drug/alcohol dependency	%	Podiatry	%
Ear/nose/throat	%	Psychiatric	%
Elective termination	%	Radiology/medical imaging	%
Gastroenterology	%	Rehabilitation	%
Gender reassignment	%	Stem cell implants	%
General practice/general medicine	%	Surgical	%
Gynaecological	%	Traditional medicine	%
In vitro fertilisation	%	Transplants	%
Obstetrics/maternity	%	Total 0	%

Do you engage in any other professional healthcare services or business activities other than those which are is described above?	Yes ☐ ▶	No ☐
▶ If Yes, please attach details of the type of work and the fee income from these other activities	$	
How many X-Ray machines are owned or operated at the premises?		
Does the applicant use Radium, or other radio-active or X-ray procedures for diagnosis or treatment?	Yes ☐	No ☐
Are any training facilities run at the premises?	Yes ☐ ▶	No ☐
▶ If Yes, please advise		

Risk Management Details

Has the applicant implemented formal risk management procedures or plans?	Yes ☐ ▶	No ☐
▶ If Yes, is adherence to these procedures periodically reviewed and are know breeches rectified?	Yes ☐	No ☐
Are there any particular characteristics of your business which would materially reduce or increase your exposure to malpractice liability claims in comparison to practitioners in your profession generally?	Yes ☐ ▶	No ☐
▶ If Yes, please advise:		

Do you ensure that all doctors providing medical services for, or using the facilities of your practice entity, carry their own medical malpractice insurance cover?	Yes ☐	No ☐ ▶
If No, are you requesting cover for these doctors as part of your application?	Yes ☐	No ☐
Do you keep accurate records and ensure all medical professionals hold valid licenses to practise in their respective specialisations issued by the relevant official authority in the country where you practice?	Yes ☐	No ☐
Do you maintain accurate and descriptive records of all medical services rendered, and equipment used in procedure?	Yes ☐	No ☐
Do you have facilities for sterilisation of instruments in accordance with relevant guidelines/standards applying to your industry?	Yes ☐	No ☐
Do you have and follow documented risk management and quality control procedures?	Yes ☐	No ☐
Are these risk management and quality control procedures regularly reviewed and updated to the appropriate standards applying to your industry?	Yes ☐	No ☐
Do you have standard procedures for the reporting of medical incidents?	Yes ☐	No ☐

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Prior Insurance

Has any insurer in respect of the risks to which this proposal relates ever:

1.	declined a proposal, refused renewal or terminated any insurance?	Yes ☐	No ☐
2.	required an increased premium or imposed special conditions?	Yes ☐	No ☐
3.	declined an insurance claim by the Applicant or reduced its liability to pay an insurance claim in full (other than by application of an Excess)?	Yes ☐	No ☐

▶ If Yes to any of the above please give details

Claims Experience

Has any claim been made against the Applicant or any principal or director (including principal or director of any previous business) consultant or employee in respect of the risks to which this proposal relates? Yes ☐ No ☐

▶ If Yes please give details *

Date of Claim or Loss	Brief details of claim or loss	Cost (if any of claim paid or loss insured)	Estimated outstanding loss
		$	$
		$	$
		$	$

What action has been taken to prevent a recurrence of the situation which gave rise to each claim or loss?

Is any principal, director, partner, consultant or employee, after enquiry, aware of any circumstances which might give rise to a claim against the Applicant or his/her predecessors in business or any present or former principals, partners, directors, consultants or employees? Yes ☐ No ☐

▶ If Yes please give details*

* *Please attach supporting documents and additional pages if necessary.*

Declaration

On behalf of all proposed Insureds, I/We declare and agree that:

1. the information and answers given in this proposal are in every respect true and correct and that Vero Liability has been made aware of all information that may be material in considering this proposal.
2. this proposal and declaration shall be the basis of and incorporated in the insurance contract.
3. I/We warrant that we will notify Vero Liability of any material alteration to these facts whether occurring before or after the completion of this insurance contract.
4. Vero Liability is authorised to give to or obtain from any other insurers or any insurance broker or other party any information relating to this insurance or any other insurance held by me/us or any claim made by me/us.

I/We understand that:

- Vero Liability is collecting the information on this proposal for the purpose of conducting its business, evaluating our insurance requirements and deciding whether to issue insurance cover and if so on what terms.
- failure to provide any of this information may result in Vero Liability refusing to provide the insurance.
- this information will be held by Vero Liability at 23-29 Albert Street, Auckland.
- I/We have certain rights of access to and correction of this information.

Signed:

Title: **Date:**

If this proposal form is being completed electronically, please print the completed form to sign.

Note: Completion of this proposal does not bind the Applicant or Vero Liability to enter into a contract of insurance.

Vero Liability Insurance Limited
Level 32 ANZ Centre, 23-29 Albert Street
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Print Form