

# RenaissanceRe

## Syndicate 1458

Registered Medical Practitioners  
Liability Insurance Proposal Form

*RenaissanceRe*

## GUIDANCE AND IMPORTANT NOTICES

### Guidance 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. This Proposal uses certain terms defined within the corresponding policy wording which should be read in conjunction with this Proposal.

### Proposal Form

This Proposal must be typed or completed in ink and signed and dated by the Proposer or an authorised representative of the Proposer. Every question must be answered accurately and fully. **NONE** or **NOT APPLICABLE** should be entered if any questions do not relate to the Insured.

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 and Reported” policy. A “Claims Made and Reported” 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 or a stipulated retroactive date. For example, where any Insured has received either an oral or written communication from or on behalf of a patient, 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, or arising from any circumstance, occurrence, fact, matter or Claim existing or happening prior to any stipulated retroactive date.

### Material Facts

The Underwriters will rely upon the material facts 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.

### Contact

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## SECTION 1 – GENERAL INFORMATION

**1.1 Name of Insured:**

## 1.2 Address:

**(a) Date of Birth:**

**(b) Contact Telephone:**

**(c) Contact Email:**

**(d) Country:**

**1.3 Please list Licensing/Registration Body with whom you hold a valid licence/membership:**

**(a)** Please provide your registration number:

**(b)** Your Registration date:

**(c)** Date of first Registration:

**1.4 Please list the associations and any other relevant regulatory bodies or organisations with which you hold a licence or membership:**

**1.5** Has membership of or registration with such licensing/registration body as listed in 1.3 and 1.4 ever been refused, suspended, withdrawn or had conditions imposed?

☐ YES    ☐ NO

If **“YES”**, please provide details on the supplementary information page

**1.6 Please denote the relevant area of medicine in which you are qualified and licensed to practice and for which you require insurance coverage (For those disciplines marked with a \*, please complete addendum 1):**

- |                                               |                                                 |                                                 |                                         |                                           |
|-----------------------------------------------|-------------------------------------------------|-------------------------------------------------|-----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Audiologist          | <input type="checkbox"/> Cardiologist           | <input type="checkbox"/> Dentists*              | <input type="checkbox"/> Dermatologist  | <input type="checkbox"/> Dietician        |
| <input type="checkbox"/> Endocrinologist      | <input type="checkbox"/> First Aider            | <input type="checkbox"/> General Practitioner   | <input type="checkbox"/> Gynaecologists | <input type="checkbox"/> Haematologist    |
| <input type="checkbox"/> Immunologist         | <input type="checkbox"/> Medical Lab Technician | <input type="checkbox"/> Microbiologist         | <input type="checkbox"/> Neurologist    | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Nurse                | <input type="checkbox"/> Nutritionist           | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Oncologist     | <input type="checkbox"/> Ophthalmologist  |
| <input type="checkbox"/> Optometrist/Optician | <input type="checkbox"/> Orthodontist*          | <input type="checkbox"/> Orthopaedics*          | <input type="checkbox"/> Paediatrician  | <input type="checkbox"/> Paramedic        |
| <input type="checkbox"/> Pathologist          | <input type="checkbox"/> Perfusionist           | <input type="checkbox"/> Pharmacist             | <input type="checkbox"/> Physiologist   | <input type="checkbox"/> Physiotherapist  |
| <input type="checkbox"/> Physicians           | <input type="checkbox"/> Prosthetist/Orthotist  | <input type="checkbox"/> Psychiatrist           | <input type="checkbox"/> Radiographer   | <input type="checkbox"/> Radiologist      |
| <input type="checkbox"/> Sonographer          | <input type="checkbox"/> Speech Therapist       | <input type="checkbox"/> Surgeon*               | <input type="checkbox"/> Urologist      | <input type="checkbox"/> Venereologist    |

If you are an Obstetrician undertaking deliveries, please state below that your area of medicine is an Obstetrician and also complete Question 2.2.

Other (please specify):

## SECTION 2 – BUSINESS INFORMATION

**2.1** Please provide details of your income (annually) based on the activity/activities for which you require cover, the number of patients you treat (annually) and the number of practice/surgical sessions you undertake a week (40 sessions = 1 week):

|                 | Income | Number of Patients | Practice/Surgical Sessions (per week) |
|-----------------|--------|--------------------|---------------------------------------|
| Previous Year:  |        |                    |                                       |
| Estimated Year: |        |                    |                                       |

**2.2** If you are an Obstetrician undertaking deliveries, please indicate the number of deliveries per annum:

|                               | NUMBER OF PATIENTS     |                                  |
|-------------------------------|------------------------|----------------------------------|
|                               | Current Financial Year | Previous Complete Financial Year |
| Vaginal                       |                        |                                  |
| Caesarean                     |                        |                                  |
| Vaginal Birth after Caesarean |                        |                                  |

**SECTION 3 – MEDICAL RECORDS****3.** 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 and in the case of a patient with mental incapacity, indefinitely.

(a) Do you maintain a record of all requests (whether written or oral) on behalf of patients for copies of medical records? ☐ YES ☐ NO

(b) Is informed consent obtained from each patient and documented in their medical record? ☐ YES ☐ NO

If “NO”, please explain how often informed consent is obtained:

**SECTION 4 – PREVIOUS INSURANCE HISTORY****4.1** Please provide full details of your previous and current medical professional liability cover:

| YEAR | Insurer/MDO | Period of Cover | Limit of Indemnity | Excess | Premium |
|------|-------------|-----------------|--------------------|--------|---------|
|      |             |                 |                    |        |         |
|      |             |                 |                    |        |         |

**4.2** Has any application for this type of insurance cover ever been:

(If any of the above are applicable, please provide detailed explanation and additional information on the supplementary information page.)

☐ Declined? ☐ Cancelled? ☐ Required any Special Terms?

**4.3** Please confirm if you require cover for past work (retroactive cover): ☐ YES ☐ NO

If “YES”, please confirm the date you have held continuous cover on a claim made basis:

**4.4** Please provide details of the Limit and Excess required:

Limit of Indemnity:

Excess:

**SECTION 5 – CLAIMS HISTORY**

**5. (a)** During the last 10 years has any claim been made, defended or settled, or has any malpractice or negligence been alleged against you? ☐ YES ☐ NO

**(b)** Are you aware of any circumstances which may result in a claim against you or any prior corporate practice, predecessors in business or any present or former partner, principle or director or professional misconduct? ☐ YES ☐ NO

**(c)** Has any partner, principal or director or member of staff ever been subject to disciplinary proceedings for professional misconduct? ☐ YES ☐ NO

If you answered “YES” to questions **5 (a), (b) or (c)**, please list all circumstances/claims over the last 10 years in a separate loss run in electronic spreadsheet format.

If your current or previous indemnity has been provided by a Medical Defence Organisation, please provide a Letter of Good Standing (LoGS).

## SECTION 6 – DECLARATION

Please use the supplementary page(s) to add any pertinent information or additional information as may be required to fully answer the questions.

I/We declare that the statements and particulars contained in the proposal are true and that I/we have not mis-stated or suppressed any material facts. I/We agree that this proposal together with any other information supplied by me/us shall form the basis of any contract of insurance effected thereon.

I/We undertake to inform Insurers of any material alteration to these facts occurring before completion of the contract of insurance. However, the duty to disclose material facts continues after the completion of the proposal form and throughout any period of insurance (and any extension thereto), upon which this proposal form was used as the basis of the contract of insurance. Signing this proposal form does not bind the proposer to complete this insurance.

Signature of authorised individual/Partner/Principal/Director:

Signature:  Date:

Print Name:

Position:  Phone:  Email:

## ADDENDUM 1 – SURGEON ADDENDUM

1. Please advise the percentage split of all types of surgery you perform:

| Surgery                      | % Split | Surgery                      | % Split |
|------------------------------|---------|------------------------------|---------|
| Bariatric                    |         | Orthopaedic                  |         |
| Cardiac                      |         | Spinal Surgery               |         |
| Elective Cosmetic            |         | Surgery (Minor)              |         |
| Elective TOP                 |         | Surgery (Intermediate)       |         |
| Gender Reassignment          |         | Surgery (Major)              |         |
| Other (Please specify below) | % Split | Other (Please specify below) | % Split |
|                              |         |                              |         |

## ADDENDUM 2 – DENTIST ADDENDUM

2. Please advise the percentage split of the dentistry work you perform:

| Area                            | % Split | Area                           | % Split |
|---------------------------------|---------|--------------------------------|---------|
| Aesthetics & Cosmetic Dentistry |         | Oral Surgery                   |         |
| Anaesthesia/Sedation            |         | Orthodontics                   |         |
| General Dentistry               |         | Surgical Periodontal Treatment |         |
| Implantology                    |         | Other (Please specify below)   | % Split |
|                                 |         |                                |         |

### ADDENDUM 3 – BARIATRIC ADDENDUM

3. (a) Do you undertake bariatric surgery? ☐ YES ☐ NO  
If "NO", proceed to Question 4 (a).
- (b) Please provide the types of procedures undertaken during the last 12 months:
- (c) Do you offer these services to patients under 18 years old? ☐ YES ☐ NO
- (d) Do you always obtain informed consent from patients prior to performing bariatric procedures? ☐ YES ☐ NO  
If "YES", please provide a copy of the template form.
- (e) Do you use criteria to exclude patients? ☐ YES ☐ NO

### ADDENDUM 4 – TELEMEDICINE ADDENDUM

4. (a) Do you undertake telemedicine services? ☐ YES ☐ NO  
If "NO", proceed to the next section.
- (b) Do you provide primary (doctor to patient) or secondary (doctor to doctor review) telemedicine?  
(i) Primary ☐ YES ☐ NO  
(ii) Secondary ☐ YES ☐ NO  
(iii) Both ☐ YES ☐ NO
- (c) Please list the countries outside your domicile in which you practice telemedicine:
- (d) How many telemedicine encounters do you average per year?
- (e) Do all providers use standardized clinical protocols when conducting telemedical interviews? ☐ YES ☐ NO
- (f) Do you confirm the existence of appropriate liability coverage? ☐ YES ☐ NO
- (g) Do you request indemnity from any institutions to whom you provide secondary telemedicine services? ☐ YES ☐ NO



**SUPPLEMENTARY INFORMATION**

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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