



# 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 **MUST** 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 not 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'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](mailto: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 name:

ii) The **Insured's** trading name (if different):

iii) How long have you been trading under the above name?

2. Have you ever carried out **Medical Services** under a different name? YES  NO

If "YES", then give full details here:

3. i) Who is the **Insured's** ultimate owner or holding company?

ii) List any corporate or private entity of USA or Canadian origin with any ownership or interest in the **Insured** or the **Insured's** ultimate owner or holding company:

Name	Origin (USA/CAN)	% Holding
		%
		%
		%

iii) How long has your current operation been managed or owned by the present parent/owner?

iv) Please give details of the **Insured's** Registered Office:

Address:

Post code:  Country:

Telephone:

Fax:

www.

Email:

v) Please give details of the **Insured's** Trading Address(es):

Address:

Post code:  Country:

Telephone:

Fax:

www.

Email:

*NB: A separate Proposal must be completed for each additional location or company to be insured, if any.*

vi) Do any of your activities involve a joint venture with any other company, partnership, individual or other professional grouping? YES  NO

vii) Will your activities involve new or incoming partners becoming involved in your activities during the next 12 months? YES  NO

If the answer is YES to either of questions vi) and vii) then please give details here:

4. i) In respect of **Medical Services** at the addresses specified above, are you in possession of the relevant licences and/or registrations from the applicable regulatory body or as required by law? YES  NO

If "NO" then give full details here:

ii) Which associations, professional bodies or self-regulatory organisations is the **Insured** a member of or registered with?

- iii) 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:

5. i) When does your financial year end?

- ii) What is your total gross fee income, turnover or gross receipts:

- a) for the last complete financial year?

- b) and an estimate for the current financial year?

6. What percentage of funding is derived from the following?

a) Government or public funds		%
b) Private funding		%
c) Charitable donations		%
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**.

## 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? YES  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		%
General beds		%
Psychiatric beds		%
Rehabilitation beds		%
Geriatric beds		%
Long stay beds		%
Hospice beds		%
Bassinets, cribs and cots		%
I.C.U./ I.T.U. beds		%
N.I.C.U.		%
Total		%

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

12. Do you have any of the following facilities: YES NO
- i) C.T./M.R.I. scanners or similar?  YES  NO  
If "YES" then is there a maintenance agreement with a third party?  YES  NO
- ii) Medical teaching facilities?  YES  NO
- iii) Nursing teaching facilities?  YES  NO
- iv) Pathology laboratories?  YES  NO
- v) Owned ambulances?  YES  NO
- vi) Owned or operated air ambulances?  YES  NO

13. i) Do you have a blood bank that procures, tests and distributes blood or blood products? YES NO  YES  NO
- ii) Average number of units of blood and blood products used per month in last 12 months:
- 
- iii) Is 100% of above obtained from National Blood Transfusion Service or National Red Cross? YES NO  YES  NO

If "NO" then give full details here:

- iv) Do you test all blood or blood products for transmittable or infectious diseases according to the current guidelines from your National Blood Transfusion Services, National Red Cross or equivalent licensing body prior to use? YES NO  YES  NO
- v) Provide full details 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 part-time employees	Independent Professional Practitioners
<b>Doctors</b>		
Residential Medical Officers		
Psychiatrists		
Other Non Procedural Physicians		
Cosmetic Surgeons		
Orthopaedic Surgeons		
Other Surgeons		
Anaesthetists		
Obstetricians / Gynaecologists		
<b>Other Medical Personnel</b>		
Midwives		
Nurses – Day		
Nurses – Night		
Pharmacists		
Paramedics		
Supplementary Professionals, including radiographers, technicians, etc.		
Complementary Professionals		
<b>Non-Medical Personnel</b>		
Directors /Partners / Principals		
Clerical / Administration		
<b>Other Personnel</b> (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 additional 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.**

16. i) Do you keep accurate records of and ensure that throughout the **Policy Period** ALL professional practitioners hold valid licences to practise in their respective specialisations issued by the relevant lawfully established and recognised licensing authority within the territories specified in the answer to Questions 3 (iv) and (v)? YES NO

- ii) Do you take up references 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 years have any professional practitioners ever been subject to disciplinary proceedings for misconduct in professional matters? YES NO

- iv) During the last 10 years, have any professional practitioners or staff members been charged or summonsed for arson, drugs, fraud, malicious damage, theft or injury to any person? YES NO

- v) Has any professional practitioner presently employed or engaged by you ever been held by a court, tribunal or similar body to have committed an act of fraud or held to have been negligent? YES NO

- vi) Has any professional practitioner or staff been found guilty of a breach of any statutory obligations, 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 facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that effective cross-infection control methods are employed? YES NO
- ii) Do you have a protocol for needlestick injuries? YES NO

If "NO" to any of Question 17, then provide details of what arrangements are in place here:

18. i) Do you maintain and will you continue to maintain accurate descriptive records of all **Medical Services** and equipment used in procedures? YES NO

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

- ii) Do you retain and will you continue to retain the records referred to above for at least ten (10) years from the date of treatment and, in the case of a minor, for at least ten (10) years after that minor attains majority? YES NO

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

- iii) Do you retain and will you continue to retain and preserve obstetric records indefinitely? YES NO

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

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

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

- 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:

## E. Public Liability Insurance Section

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: YES  NO

(i) public liability insurance?  YES  NO

(ii) workers' compensation insurance?  YES  NO

(iii) do you require copies of these policies or inspect copies of these policies?  YES  NO

21. i) Do the premises comply with current fire precaution and prevention requirements? YES  NO

ii) Are staff instructed in and kept regularly appraised on fire and emergency procedures? YES  NO

iii) Is there an emergency electrical system? YES  NO

If the answer is "NO" to any of Questions 20 or 21 above, then please provide full details in the following supplementary information box:

22. i) Are there facilities for safe collection, storage and disposal, in accordance with current guidelines or legislation of:

a) Sharps? YES  NO

b) Dressings, clinical and surgical waste, etc.? YES  NO

ii) Do you ensure that the following are safely disposed of, in accordance with current guidelines/legislation: YES  NO

a) blood and blood products?  YES  NO

b) all other waste?  YES  NO

If you have answered "NO" to any of the questions in 22 above then provide full details here:

23. i) Do you require cover for liability arising from **Products**? (NB. The standard policy excludes liability arising from **Products** other than Food and Drink). YES  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**? YES  NO

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 insured **Excess**?

Medical Professional Liability:

Public Liability:

v) What is the expiry date?

Medical Professional Liability:

Public Liability:

vi) Please give full details of all similar insurance held during the past 5 years (below):

Policy Year	CM LO	Retroactive Date	Limit of Indemnity Any One Claim	Limit of Indemnity Any One Year	Deductible Self Insured Excess

Note: CM = **Claims Made**  
LO = **Losses Occurring**

26. i) Has any application for these types of insurance coverage ever:

- a) been returned or declined? YES  NO
- b) been cancelled or had renewal refused? YES  NO
- c) had special terms imposed? YES  NO

ii) During the last 10 years have you ever had any insurer allege a failure to notify circumstances and/or report a **Claim** in a timely manner in accordance with policy conditions? YES  NO

iii) During the last 10 years have you notified circumstances to any insurer of which you were aware, for example, an allegation of negligence, error, omission, misleading conduct, which subsequently resulted in a **Claim**? YES  NO

iv) During the last 10 years has any previous insurer alleged a breach of utmost good faith by you or your predecessors in business or any present or former principal, partner or director? YES  NO

v) Following a full investigation, are any of the principals, partners, directors or staff aware of any matter, occurrence or circumstance, which may result in any **Claim** against you or your predecessors in business or any present or former principal, partner, director or professional practitioner? YES  NO

vi) Following a full investigation, are any of the principals, partners, directors or staff aware of any accounts overdue for payment where there is reason to believe that the patient or client is dissatisfied with the professional services rendered? YES  NO

If the answer to any of the 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:

*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	
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		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 <b>Claim</b>	
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 Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details – including nature of the allegations and details of Claimant	Notified to and accepted by previous Insurers or Medical Defence Organisation

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

DATE

NAME OF PROPOSER

POSITION HELD

(IN BLOCK CAPITALS PLEASE)

## 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

1. Describe the fertility services you provide in the space below and attach any brochures or publications you issue:
- 
2. Do you perform genetic manipulations? YES  NO
3. Are you involved with genetic selection? YES  NO
4. Are any changes to the above activities anticipated in the next 12 months? YES  NO
5. Do you operate a sperm bank? YES  NO

If the 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. Is all donor semen cryopreserved and quarantined in line with current recommendations? YES  NO
8. What are your gross revenues and fees from the provision of such services?

Last complete financial year:

Current financial year estimate:

## Addendum C – Keyhole Surgery

1. Do all surgeons performing keyhole surgery procedures have specific training in this technology? 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. Is the procedure explained to the patient and his/her consent obtained? YES  NO
5. Are policies and procedures in place to ensure the following are carried out:
- i) Explaining the nature of procedures to patients and obtaining their consent? YES  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:



# Additional Information

*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.