MEDICAL MALPRACTICE APPLICATION

IMPORTANT NOTICE

Before you enter into a contract of general insurance with an insurer, you have a duty to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, upon what terms.

You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of general insurance.

Your duty, however, does not require disclosure of matter:

- That diminishes the risk to be undertaken by the insurer;
- That is of common knowledge;
- That your insurer knows, or in the ordinary course of its business, ought to know;
- As to which compliance with your duty of disclosure is waived by the insurer.

If you fail to comply with your duty of disclosure, Underwriters may be entitled to reduce their liability under the contract in respect of a claim or may cancel the contract. If your non-disclosure is fraudulent, Underwriters may also have the option of avoiding the contract from its beginning.

Please answer ALL questions fully. If there is insufficient space, please provide further details on a supplementary sheet noting which question number the additional information relates to.

The Applicant will be referred to in this application as "You" or "Your".

APPLICANT INFORMATION

1. Full name of all entities to be insured (including details on service, administrative or nominee companies and subsidiaries that you wish to be covered by this policy):

2. Principal Mailing Address:

3. Address(es) of branch offices or other locations.

4. Date on which your Practice was established:

5. Please supply the following details:

				Period Practicing as Partner, Principal or Director	
Names of Partners, Principals and Directors	Age	Qualifications	Date Qualified	This practice	Previois practices

6. Please supply total numbers of:

Partners, principals, directors	
Qualified Staff (please specify):	
Other technical staff	
Trainee staff	
Non-technical administrative staff	
Clerical staff	
Other staff (please specify)	
Total of all staff:	

**For Sole Proprietors Only - Questions 7 and 8.*

7. State the experience of your assistants and their length of service and, or any training provided.

8. What arrangements do you have to assist you during your temporary absence on business, leave, sickness, or unforeseen emergency?

DETAILS OF YOUR PRACTICE

9. Has the name of the practice ever been changed? ☐ Yes ☐ No

10. Has any other practice or business amalgamated or merged with you? ☐ Yes ☐ No

11. Have you purchased any other practice or business? ☐ Yes ☐ No

If you have answered Yes to any of the above, please supply details:

12. Is any partner, principal or director connected or associated (financially or otherwise) with any other practice or business? ☐ Yes ☐ No
If Yes, please supply details:

13. Please list the professional bodies or associations to which you belong.

14. Please detail your total fee income:

For the last 12 months:	
Estimated for the next 12 months:	

15. Please provide an approximate percentage split of your fee income derived from the following fields of work: (Total Must Equal 100%)

Acupuncture		Osteopathy	
Audiology		Pathology	
Chemical, Pharmaceutical		Podiatry	
Chiropractic		Chiropody	
Dentistry, Orthodontics		Psychology	
Occupational therapy		Physiotherapy	
Massage		Clinic research	
Naturopathy		Home nursing	

Nutrition, Dietetics		Beauty Therapy / Aesthetics	
Speech therapy		Hair and scalp treatment	
Osteopathy		Other (Complete following questions)	

16. Complete if applicable
Please provide details of the precise nature of activities or business.

Please categorise the specific activities or business outlined described above and indicate the approximate percentage of your fee income derived from same.

Please provide details of any advice given and/or your informed consent procedures in relation to the activities or business outlined described above.

Are verbal reports always confirmed in writing? ☐ Yes ☐ No
If No, how do you substantiate such verbal reports?

17. / Does any contract or client represent more than 50% of your annual work or fees?
☐ Yes ☐ No

18. What is the average number of patient visits per day?

19. Do you engage consultants, sub-contractors or agents? ☐ Yes ☐ No
If Yes
Do you require them to carry their own professional indemnity or malpractice insurance?
☐ Yes ☐ No
Do you enter into any hold-harmless agreements or otherwise waive any legal rights or entitlements which you may have against such consultants, sub-contractors or agents?
☐ Yes ☐ No

20. Do you envisage any substantial changes in your activities or are there any major new operations contemplated during the next 12 months? ☐ Yes ☐ No
If Yes, please supply details.

21. Do you perform work outside of your country of domicile or work for clients located outside of Canada? ☐ Yes ☐ No
If Yes, please supply details and approximate percentage per country.

22. Do you hold all client records for a minimum of 7 years or in line with the industry standards and/or requirements? ☐ Yes ☐ No

23. Do you have any abuse protocols in place? ☐ Yes ☐ No
If Yes, please supply a copy of this document.

CLAIMS DETAILS

24. Has any partner, principal, director or staff member ever been subject to disciplinary proceedings for professional misconduct? ☐ Yes ☐ No
If Yes, please supply details.

25. Have any claims for negligence or breach of professional duty been made in the last ten (10) years against you or your practice or any of its predecessors in business or any prior practice of any of your present or former partners, principles or directors, or have circumstances been notified to insurers that might give rise to a claim? ☐ Yes ☐ No
If Yes, please supply details.

Date Matter Notified	Name of Insurer (if any)	Name of Clairmant or Potential	Brief Description	Amount paid or estimate of Potential Liability	Is Matter Finalised or Outstanding

26. Are any of the Partners, principals or directors, after enquiry, aware of any claim or circumstances that might give rise to a claim against the practice or any prior practice or any of its present or former partners, principals or directors? ☐ Yes ☐ No
If Yes, please provide the following details in respect to each matter.

Name of Claimant or Potential Claimant	Brief Description of the Matter	Estimate of Potential Liability

DETAILS OF INSURANCE COVER

27. Does the Practice presently carry, or has the Practice ever carried, malpractice liability insurance? ☐ Yes ☐ No
If Yes, please supply details.

Insurer:	
Expiry Date:	
Limit of Indemnity:	
Premium:	
Retroactive date:	

28. Has the Practice or any partner, principal or director ever been refused this type of insurance, or had similar insurance cancelled, or had an application of renewal declined, or had special terms imposed? ☐ Yes ☐ No
If Yes, please supply details.

APPLICATION FOR COVER

Limit of indemnity required:	
Deductible, excess requested: (applicable to each and every claim)	

DECLARATION

I am / we are the undersigned authorised Insured Person(s) and after enquiry I / we can declare as follows:

I am or we are authorised by each of the other applicants to make this application.

I or we have read this application and the accompanying documents and acknowledge the contents of same to be true and complete.

I or we understand that, up until a contract of insurance is entered into, I or we are under a continuing obligation to immediately inform the Insurer of any change in the particulars or statements contained in this application or in the accompanying documents.

Although the signing of this application does not bind the applicants to effect insurance the applicants acknowledge that the particulars and statements contained in this application and in the accompanying documents shall be the basis of the contract should a policy be issued; and further, the applicants acknowledge that the application and the accompanying documents will be incorporated in the policy.

Signature: _____

Date: _____

Please send the completed, signed and dated application to underwriting@revau.com

CARE SUPPLEMENT

1. Confirmation that all non-medically qualified staff are fully trained and signed off as competent by an employed qualified medical practitioner/nurse as fully competent to provide care services, following a period of supervision and are all working towards their qualifications where they do not already hold. ☐ Confirmed
   Details if any:

2. Confirmation that insured provides full training in lifting and hoisting, dementia care, challenging behaviour, H&S, needle stick injuries etc and regular refresher training on these subjects and evidence of attendance are kept and signed off in employees records.
   ☐ Confirmed
   Details if any:

3. Confirmation that only nurses and well trained, experienced (senior level) care staff undertake any nursing care procedures, such as peg feeding, catheter care, etc.
☐ Confirmed
Details if any:

4. Please give full details as to any risk management implemented (or to be implemented) following recommendations/requirements by your local quality, standard of care inspectors.

5. Please advise how you manage staff shortages to ensure that you have enough staff to manage the number of and specific care requirements of the service users at each home.

6. Please confirm that you do not provide any care services to those who are currently detained under the Mental Health Act or operate any high secure units. ☐ Confirmed
Details if any:

7. Do any of the employed nurses have any prescribing duties? ☐ Yes ☐ No
If yes please full details (e.g. how many, what drugs and the risk management procedure surrounding this etc)

8. Have you taken over any existing care providers following poor management and please give feedback as to how you have turned these homes around to provide high standards of care.

9. In terms of management of the homes, what checking procedures do you undertake on the experience and qualifications of the manager? Do you have prerequisite requirements?

10. Confirmation that all care plans are written and agreed by a GP who holds their own malpractice, errors and omissions cover. ☐ Confirmed
Details if any:

11. Confirmation that all complementary therapists (i.e. hairdressers, chiropodists, massage therapists etc) hold their own cover as individuals, if not please advise numbers and roles.
☐ Confirmed
Details if any: