Medical Malpractice Corporate

Insurance application form

The purpose of this application form is for us to find out more about you. You must provide us with all information which may be material to the cover you wish to purchase and which may influence our decision whether to insure you, what cover we offer you or the premium we charge you.

How to complete this form

The individual who completes this application form should be a senior member of staff at the company and should ensure that they have checked with other senior managers and colleagues responsible for arranging the insurance that the questions are answered accurately and as completely as possible. Once completed, please return this form to your insurance broker.

Section 1: General Information

1.1 Insured name:

Contact name:

Address:

Postcode: Telephone:

Email address: Website:

1.2 Please state:

the date the business was established (DD/MM/YYYY): the date the business started trading (DD/MM/YYYY):

1.3 Please provide details of all trading addresses, including any overseas trading addresses, below:

Address 1:

Address 2:

Address 3:

Address 4:

1.4 Please state the legal structure of the business:

Charity/Not-for-profit: ☐ Public: ☐

Private: ☐ Other: ☐

If you have selected "other", please provide full details:

1.5 Please state whether you have ever carried out any activities under any other name or have been part of a merger or de-merger: ☐ Yes ☐ No

If "yes", please provide full details:

1.6 Please state whether there is any overseas corporate entity or private individual that has or has ever had an interest in or ownership or control of the business: ☐ Yes ☐ No

If "yes", please provide full details, including the country of registration of the overseas corporate entity or country of residence of the private individual:

1.7 Please state whether you are a member of, or are registered with, any associations, professional bodies or self-regulatory organisations: ☐ Yes ☐ No

If "yes", please provide full details:

1.8 Please state whether you hold a valid licence, or are registered with an appropriate regulatory body or as otherwise required by law, to practice your business: ☐ Yes ☐ No

If "no", please explain why not:

1.9 Please state whether you have ever been refused membership of any association, professional body or self-regulating organisation or have had any licence suspended, revoked or had special conditions imposed: ☐ Yes ☐ No

If "yes", please provide full details:

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Section 2: Medical Services Information

2.1 Please state the annual turnover in respect of the following years:

	Last complete financial year	Current financial year	Estimate for next financial year
Domestic:			
Europe:			
USA/Canada:			
Rest of the World:			
Total:			

2.2 Please describe below the professional healthcare services provided by your business:

2.3 Please state the number of patients or clients you have treated or expect to treat in respect of the following years:

Last complete financial year:	Current financial year:	Estimate for next financial year:

2.4 In respect of the activities below, please state the estimated total number of:

a) individual transports and treatments for ambulatory/paramedic services for the following years:

Last complete financial year:	Current financial year:	Estimate for next financial year:

b) prescriptions for pharmacy services for the following years:

Last complete financial year:	Current financial year:	Estimate for next financial year:

c) individual treatments over the following years for:

	Last complete financial year:	Current financial year:	Estimate for next financial year:
Beauty therapy services:			
Cosmetic surgery:			
Cosmetic/aesthetic services (non-surgical):			
Fertility/assisted conception			
Hyperbaric clinic/services:			
Ophthalmic surgery services (laser/refractive eye):			
Ophthalmic surgery services (other):			
Sports medicine/injury services:			
Minor surgery:			

d) individual tests and scans over the following years for:

	Last complete financial year:	Current financial year:	Estimate for next financial year:
Diagnostic and scanning services (including MRI and CAT scanning):			
Obstetric services:			
Pathology/laboratory services (including the interpretation of results):			
Pathology/laboratory services (excluding the interpretation of results):			

e) individual patients over the following years for:

	Last complete financial year:	Current financial year:	Estimate for next financial year:
Acquired brain injury rehabilitation services (outpatient):			
Alternative/complementary medicine:			
Clinical trials:			
Counselling:			
Dentistry:			
Dialysis services:			
Domciliary care services:			
GP/primary care services:			
Leaning disability services:			
Occupational health services:			
Opticians/optometry services:			
Out-of-hours primary care services:			
Physiotherapy/rehabilitation services:			
Sexual health services:			
Telemedicine/remote services:			

2.5 Please state your estimated annual turnover for following years in respect of:

	Last complete financial year:	Current financial year:	Estimate for next financial year:
Blood bank/plasma services:			
Health and fitness services:			

2.6 If you provide any healthcare services other than the ones detailed in 2.4 a) - e) and 2.5, please provide full details:

2.7 Please state whether you provide any inpatient facilities at the premises: ☐ Yes ☐ No

	Number of beds	Average number of beds occupied daily
Acute care beds:		
Acute psychiatric beds:		
Acquired brain injury/rehabilitation beds:		
Addiction/rehabilitation treatment beds:		
Bassinets, cribs and cots:		
Elderly care beds:		
Hospice/palliative care beds:		
ICU/HDU beds:		
Learning disability beds:		
Nursing home beds:		
Psychiatric rehabilitation beds:		
TOTAL:		

2.8 Please state whether you anticipate any material changes to the activities or the business in the next 12 months: ☐ Yes ☐ No

If "yes", please provide full details:

2.9 Please state whether you provide or have any interest in any medical or nursing teaching facilities or whether training is provided to individuals not employed by the business: ☐ Yes ☐ No

If "yes", please provide full details:

2.10 Please state whether you publish advice or offer medical diagnosis or treatment over the internet or any other electronic medium, for example, phone apps: ☐ Yes ☐ No

If "yes", please provide full details:

2.11 Please provide a full occupational breakdown for the number of medically qualified staff in the categories below and state whether you require cover for them:

	Full time staff:	Part time staff:	Self-employed staff:	Cover required:
Anaesthetists:				☐ Yes ☐ No
Audiologists				☐ Yes ☐ No
Beauty therapists:				☐ Yes ☐ No
Care staff:				☐ Yes ☐ No
Chiropodists/podiatrists:				☐ Yes ☐ No
Chiropractors/osteopaths:				☐ Yes ☐ No
Clinical scientists/specialists:				☐ Yes ☐ No
Complementary therapists:				☐ Yes ☐ No
Dentists:				☐ Yes ☐ No
Dental care practitioners:				☐ Yes ☐ No
Dieticians/nutritionists:				☐ Yes ☐ No
General Practitioners:				☐ Yes ☐ No
General surgeons:				☐ Yes ☐ No
Gynaecologists:				☐ Yes ☐ No
Laboratory technicians:				☐ Yes ☐ No
Midwives:				☐ Yes ☐ No

Nurse anaesthetists:				☐ Yes ☐ No
Nurse practitioners:				☐ Yes ☐ No
Nurses - general:				☐ Yes ☐ No
Obstetricians:				☐ Yes ☐ No
Occupational therapists:				☐ Yes ☐ No
Ophthalmologists:				☐ Yes ☐ No
Optometrists:				☐ Yes ☐ No
Orthopaedic surgeons:				☐ Yes ☐ No
Paramedics/first aiders:				☐ Yes ☐ No
Pharmacists:				☐ Yes ☐ No
Physicians:				☐ Yes ☐ No
Physiotherapists:				☐ Yes ☐ No
Plastic/cosmetic surgeons:				☐ Yes ☐ No
Prosthetists/orthotists:				☐ Yes ☐ No
Psychologists:				☐ Yes ☐ No
Psychiatrists:				☐ Yes ☐ No
Radiographers:				☐ Yes ☐ No
Radiologists:				☐ Yes ☐ No
Resident medical officers (RMO):				☐ Yes ☐ No
Speech and language therapists:				☐ Yes ☐ No
Surgeons - other:				☐ Yes ☐ No
Other clinical personnel:				☐ Yes ☐ No

If you have selected "other clinical personnel", please provide full details:

2.12 Please provide a full occupational breakdown for the number of supplementary and non-medical staff in the categories below and state

	Full time staff	Part time staff	Self-employed staff	Cover required?
Clerical/administrative:				☐ Yes ☐ No
Directors/partners/principals:				☐ Yes ☐ No
Other non-clinical personnel:				☐ Yes ☐ No

If you have selected "other non-clinical personnel", please provide full details:

Please state whether all staff listed in 2.11 and 2.12:

a) hold their own professional indemnity insurance or maintain indemnity via a Medical Defence Organisation: ☐ Yes ☐ No

b) provide evidence of the coverage in force on an annual basis, as part of your practitioner credentialing process: ☐ Yes ☐ No

c) are re-credentialed on at least an annual basis, or in line with any professional or statutory requirement, where required: ☐ Yes ☐ No

d) are registered with the appropriate regulatory body(s): ☐ Yes ☐ No

If you answered "no" to any of a) to d) above, please provide full details:

2.14 Please state whether the following are undertaken for all full-time, part-time, temporary and contract staff and valid records maintained:

a) references obtained and any professional qualifications validated: ☐ Yes ☐ No

b) appropriate police background checks: ☐ Yes ☐ No

c) the provision of adequate and appropriate training and validation of competency skills: ☐ Yes ☐ No

d) the arrangement of supervision is in place under the appropriate management: ☐ Yes ☐ No

If you answered "no" to a), b), c) or d) above, please explain why not:

2.15 Please state whether you sub-contract any work: ☐ Yes ☐ No

If "yes", please provide full details of the nature of the sub-contracted work, including any one-off projects:

If you answered "yes" to 2.15, please state whether all sub-contractors maintain their own medical liability insurance with a limit of liability that is no less than the limit of liability maintained by you and whether the sub-contractors provide evidence of the insurance that is in force: ☐ Yes ☐ No

If "no", please explain why not:

2.16 In your opinion, which of your business activities are likely to give rise to a claim against you?

2.17 Please state whether you enter into any written agreements or whether you operate under a standard form of contract: ☐ Yes ☐ No

If "yes", please provide a copy.

2.18 Please state whether there is any other information that you think should be disclosed to us for which cover is required: ☐ Yes ☐ No

If "yes", please provide full details (including details of any part time activities or details of any associated companies):

Section 3 - Risk Management Information

3.1 Please state who is responsible for the Clinical Risk Management in your business:

Name: Position:

Date joined: Qualifications:

3.2 Please state whether you have a formal documented risk management programme: ☐ Yes ☐ No

If "yes", please attach a copy of the programme to this application.

3.3 Please state whether you have a formal programme for clinical quality assurance: ☐ Yes ☐ No

If "yes" please provide full details and attach a copy of the programme to this application, including how you maintain your clinical quality and how you benchmark your clinical quality assurance against your peers:

3.4 Please state whether you have a written procedure for reporting incidents or other adverse events: ☐ Yes ☐ No

If "yes", please state who handles incidents or other adverse events:

3.5 Please state whether the medical records held by you are in written or electronic form:

3.6 Please state whether informed consent is always obtained from each patient prior to treatment and documented in the patient's medical record: ☐ Yes ☐ No

If "no", please explain why, including the circumstances under which you would always obtain written consent and the circumstances under which you would not.

3.7 Please state whether there are facilities at the business premises for the sterilisation of instruments in accordance with current guidelines and whether cross infection control procedures are adhered to: ☐ Yes ☐ No

If "no", please explain why not:

3.8 Please state whether the current guidelines for the safe collection and disposal of any clinical or medical waste products are complied with: ☐ Yes ☐ No

3.9 Please state whether you have a protocol in place for needle-stick injuries? ☐ Yes ☐ No

If "no", please explain why not:

3.10 Please state whether you have been, are currently involved in or are planning any clinical trials which you require cover for? ☐ Yes ☐ No

If "yes", please provide full details:

Section 4 - Cyber Security Risk Management

4.1 Please describe the type of sensitive information you hold and provide an approximate number of unique records that you store or process:

4.2 Please describe the most valuable data assets you store:

4.3 Please state:

a) who is responsible for IT security within your business (by job title):

b) how many years have they been in this position:

c) whether you comply with any internationally recognised standards for information governance: ☐ Yes ☐ No

If you answered "yes" to c) above, please state the internationally recognised standards with which you comply:

4.4 Please tick all the boxes below that relate to companies or services where you store sensitive data or who you rely upon to provide critical business services:

☐ Adobe	☐ Amazon Web Services	☐ Dropbox	☐ Google Cloud
☐ IBM	☐ Microsoft 365	☐ Microsoft Azure	☐ Oracle Cloud
☐ Salesforce	☐ SAP	☐ Workday	

4.5 Please tick all the boxes below that relate to controls that you currently have implemented within your IT infrastructure (including where provided by a third party). If you're unsure of what any of these tools are, please refer to the explanation on the final page of this document.

☐ Advanced Endpoint Protection	☐ Application Whitelisting	☐ Asset Inventory	☐ Custom Threat Intelligence
☐ Database Encryption	☐ Data Loss Prevention	☐ DDoS Mitigation	☐ DMARC
☐ DNS Filtering	☐ Employee Awareness Training	☐ Incident Response Plan	☐ Intrusion Detection System
☐ Mobile Device Encryption	☐ Penetration Tests	☐ Perimeter Firewalls	☐ Security Info & Event Management
☐ Two-factor Authentication	☐ Vulnerability Scans	☐ Web Application Firewall	☐ Web Content Filtering

4.6 Please provide the name of the software or service provider that you use for each of the controls highlighted in 4.5:

Section 5 - Claims Experience

Please answer the following questions. Please consider all relevant information and if in doubt, refer to your broker. Regarding all types of insurance to which this application form applies:

After full enquiry:

a) i. has any claim, complaint* or allegation of negligence been made against you during the last 10 years (even if there was a favourable outcome)? ☐ Yes ☐ No

ii. has there been any form of disciplinary action or investigation for professional misconduct? ☐ Yes ☐ No

iii. has there been any statutory sanction against you: ☐ Yes ☐ No

iv. have you ever been subject to any adverse findings, conditions, suspension or erasure by a regulator, registration body or equivalent? ☐ Yes ☐ No

b) is there any incident or circumstance which may lead to any claim, complaint* or allegation of negligence or disciplinary action or investigation? ☐ Yes ☐ No

c) has there been a loss of data that has resulted in a privacy breach? ☐ Yes ☐ No

d) has any insurer ever declined to insure you, imposed any special terms, cancelled or declined to renew your insurance? ☐ Yes ☐ No

*Please note that "complaint" includes but is not limited to any verbal or written complaint or any expression of dissatisfaction.

If the answer to any of the above is "yes", then please attach full details including an explanation of the background of events, all relevant dates, the status of the claims or circumstances, the maximum amount involved or claimed and any reserves or payments made.

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Section 6 - Indemnity History and Requirements

6.1 Please advise the first date that coverage is required: (DD/MM/YYYY)

6.2 Please provide details of your current and previous indemnity arrangements and what you now require for this insurance:

	Retroactive Date (MM/YY)	Effective Date (MM/YY)	Limit	Deductible	Premium	Insurer	Claims made bass
Previous:							☐ Yes ☐ No
Previous:							☐ Yes ☐ No
Previous:							☐ Yes ☐ No
Previous:							☐ Yes ☐ No

6.3 Please provide details of the territories or legal jurisdiction(s) in which you require coverage:

6.4 Please indicate below if you would like any of the following covers included in addition to your Medical Malpractice quote:

☐ Professional indemnity ☐ Cyber Liability

Important Notice

By signing this form you agree that the information provided is both accurate and complete and that you have made all reasonable attempts to ensure this is the case by asking the appropriate people within your business. PAL Insurance will use this information solely for the purposes of providing insurance services and may share your data with third parties in order to do this. We may also use anonymised elements of your data for the analysis of industry trends and to provide benchmarking data. For full details on our privacy policy please visit www.palcanada.com.

Contact Name: Position:

Signature: Date (DD/MM/YYYY):

Cyber security controls explained

Please note that this information page is only relevant if you are purchasing Cyber Liability coverage.

Advanced endpoint protection

Software installed on individual computers (endpoints) that uses behavioural and signature based analysis to identify and stop malware infections.

Application whitelisting

A security solution that allows organisations to specify what software is allowed to run on their systems, in order to prevent any nonwhitelisted processes or applications from running.

Asset inventory

A list of all IT hardware and devices an entity owns, operates or manages. Such lists are typically used to assess the data being held and security measures in place on all devices.

Custom threat intelligence

The collection and analysis of data from open source intelligence (OSINT) and dark web sources to provide organisations with intelligence on cyber threats and cyber threat actors pertinent to them.

Database encryption

Where sensitive data is encrypted while it is stored in databases. If implemented correctly, this can stop malicious actors from being able to read sensitive data if they gain access to a database.

Data loss preventions

Software that can identify if sensitive data is being exfiltrated from a network or computer system.

DDoS mitigation

Hardware or cloud based solutions used to filter out malicious traffic associated with a DDoS attack, while allowing legitimate users to continue to access an entity's website or web-based services.

DMARC

An internet protocol used to combat email spoofing – a technique used by hackers in phishing campaigns.

DNS filtering

A specific technique to block access to known bad IP addresses by users on your network.

Employee awareness

Training programmes designed to increase employees' security awareness. For example, programmes can focus on how to identify potential phishing emails.

Incident response plan

Action plans for dealing with cyber incidents to help guide an organisation's decision-making process and return it to a normal operating state as quickly as possible.

Intrusion detection system

A security solution that monitors activity on computer systems or networks and generates alerts when signs of compromise by malicious actors are detected.

Mobile device encryption

Encryption involves scrambling data using cryptographic techniques so that it can only be read by someone with a special key. When encryption is enabled, a device's hard drive will be encrypted while the device is locked, with the user's passcode or password acting as the special key.

Penetration tests

Authorised simulated attacks against an organisation to test its cyber security defences. May also be referred to as ethical hacking or red team exercises.

Perimeter firewalls

Hardware solutions used to control and monitor network traffic between two points according to predefined parameters.

Security info & event management (SIEM)

System used to aggregate, correlate and analyse network security information – including messages, logs and alerts – generated by different security solutions across a network.

Two-factor authentication

Where a user authenticates themselves through two different means when remotely logging into a computer system or web based service. Typically a password and a passcode generated by a physical token device or software are used as the two factors.

Vulnerability scans

Automated tests designed to probe computer systems or networks for the presence of known vulnerabilities that would allow malicious actors to gain access to a system.

Web application firewall

Protects web facing servers and the applications they run from intrusion or malicious use by inspecting and blocking harmful requests and malicious internet traffic.

Web content filtering

The filtering of certain web pages or web services that are deemed to pose a potential security threat to an organisation. For example, known malicious websites are typically blocked through some form of web content filtering.

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Additional Information