**Medical Malpractice for institutions Proposal Form**

**(Hospital, Clinics, Nursing Homes etc…)**

PLEASE READ THESE GUDANCE NOTES BEFORE COMPLETING THE PROPOSAL FORM. WHERE FURTHER INFORMATION IS REQUIRED PLEASE REFER TO YOUR BROKER / INSURANCE AGENT.

**PLEASE NOTE** This Proposal Form is for a CLAIMS MADE policy. A CLAIMS MADE policy only responds to “claims” made against the insured and notified to Underwriters during the period of insurance.

* The Proposal Form must be typed, or completed in ink and signed and dated by the Proposer. Please answer every question fully, and state “NIL” or “NONE” as applicable. Incomplete answers may not be accepted and can delay quotation.
* Where more than one location or establishment is to be included in the quotation, please complete a separate proposal form for each location or establishment.
* Please submit, with the Proposal, all relevant information including Financial Report and Accounts, Brochures, Consent Forms etc.
* Should there be insufficient room in the Proposal form for full details, please attach further information on signed and dated sheets, wherever possible following the same format and question number.
* It is the duty of the Proposer to disclose all material facts to Insurers. Where this is omitted, the Underwriters may avoid their obligation under the Policy.

For the purpose of the Proposal and for all purposes relating to any policy issued pursuant to this Proposal, a ‘material fact’ shall be deemed to be one that would be likely to influence an Underwriter’s judgment and acceptance of your Proposal.

* Upon acceptance of the Underwriters’ terms and conditions and payment of the premium, all information provided by the Proposer together with the guidance notes will be deemed to be incorporated in the contract between Underwriters and the Insured.

**Copies of the Proposal Forms should be retained for your own records.**

1. i) Full name of the Insured:

|  |
| --- |
|  |

 ii) Trading name if different from above:

|  |
| --- |
|  |

 iii) How long has the establishment been trading under the
 above name?

|  |
| --- |
|  |

2. Have you ever engaged in a similar activity under a different
 name?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘YES’ please see Question 6 and provide full details in the
 same numerical order on a separate sheet.

3. i) Trading address

|  |
| --- |
|  |
|  |
|  |
| Postal Code: | Country: |
| Telephone: |
| Fax: |
| Website: |

 ii) Registered office (if different from above)

|  |
| --- |
|  |
|  |
|  |
| Postal Code: | Country: |
| Telephone: |
| Fax: |
| Website: |

 NB: If cover is required for additional locations, a separate

 proposal form for each must be completed.

4. i) Please name the ultimate Owner or Holding Company:

|  |
| --- |
|  |

 ii) Please identify any corporate or private entity of either USA or Canadian origin that has any ownership or interest in either the Insured or the Insured’s ultimate owner or holding company.

|  |
| --- |
|  |
|  |

 iii) Length of current operation by present Parent/Owner:

|  |
| --- |
|  |

5. Please state your total Gross Fee Income/ Turnover / Gross Receipts:

|  |  |
| --- | --- |
|  i) for the past Financial Year |  |
| ii) estimated for current Financial Year |  |

6. **PLEASE GIVE A FULL DESCRIPTION OF YOUR BUSINESS ACTIVITIES FOR WHICH COVER IS REQUIRED (this must be answered):**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

7. i) What percentage of funds are generated from:

|  |  |
| --- | --- |
| a) Government / Public? | % |
| b) Private funding? | % |
| c) Charitable donations? | % |

 ii) What are the approximate percentages of patients from:

|  |  |
| --- | --- |
| a) Government / Public? | % |
| b) Private funding? | % |
| c) Charitable donations? | % |

 iii) What, if any, substantial changes in your activities or major new developments are likely to occur within the next 12 months? Please give full details:

|  |
| --- |
|  |
|  |
|  |

8. i) Are you licensed and registered in accordance with applicable regulatory body or law to practice those procedures at the address specified in question 3 for which indemnification is required?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘NO’ please give full details:

|  |
| --- |
|  |
|  |
|  |

 ii) Are you a member of any Association or Professional Body,

 or registered with any self-regulating Organization?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘YES’ please state which:

|  |
| --- |
|  |
|  |
|  |

 iii) Has membership or registration with such ever been

 suspended, withdrawn, amended, declined or had

 conditions attached?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘YES’ please give full details:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

9. Does the Establishment have:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| i) C.A.T./ M.R.I. Scanners or similar? | Yes |  |  | NO |  |

 If ‘YES’ please provide details of any maintenance agreement:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ii) Medical teaching facilities? | Yes |  |  | NO |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| iii) Nursing teaching facilities? | Yes |  |  | NO |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| iv) Pathology Laboratory? | Yes |  |  | NO |  |

|  |  |  |
| --- | --- | --- |
| v) Any ambulance owned? |  |  |

|  |  |
| --- | --- |
| vi) Any air ambulance owned/operated? |  |

10. i) Please state the total number of beds and average daily

 Occupancy:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Number |  | A.D.O |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Beds |  | k |  | % |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bassinets/Cribs/Cots |  |  |  | % |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I.C.U./I.T.U. |  |  |  | % |

 ii) Please state the total number of admitted in-patients

|  |  |
| --- | --- |
| Last year |  |

|  |  |  |
| --- | --- | --- |
| Please state what if any, percentage of your  |  |  |
| patients came from USA or Canada |  | % |

|  |  |  |
| --- | --- | --- |
| Please state what if any, percentage of your  |  |  |
| clients who may be resident in Britain from |  |  |
| USA or Canada  |  | % |

11. i) Please identify the approximate percentages of procedures performed on ADMITTED in-patients within the following categories:

|  |  |
| --- | --- |
| Accident & Emergency\* (Addendum 5) |  |

|  |  |
| --- | --- |
| Assisted Conception\* (Addendum 1) |  |

|  |  |
| --- | --- |
| Clinical Trials\* (Addendum 2) |  |

|  |  |
| --- | --- |
| Communicable Diseases |  |

|  |  |
| --- | --- |
| Drug/Alcohol Dependency |  |

|  |  |
| --- | --- |
| Dental |  |

|  |  |
| --- | --- |
| Elective Cosmetic |  |

|  |  |
| --- | --- |
| Elective T.O.P.\* (Addendum 4) |  |

|  |  |
| --- | --- |
| Gender Reassignment |  |

|  |  |
| --- | --- |
| Geriatric |  |

|  |  |
| --- | --- |
| Maternity/Obstetrics\*(Addenda 3&5) |  |

|  |  |
| --- | --- |
| Organ Transplant  |  |

|  |  |
| --- | --- |
| Paediatric |  |

|  |  |
| --- | --- |
| Psychiatric |  |

|  |  |
| --- | --- |
| Tropical Diseases |  |

|  |  |
| --- | --- |
| Other Minor Surgery  |  |

|  |  |
| --- | --- |
| Intermediate Surgery  |  |

|  |  |
| --- | --- |
| Major Surgery  |  |

|  |  |
| --- | --- |
| Keyhole Surgery  |  |

|  |  |
| --- | --- |
|  | Total 100% |

**Where indicated with an \* please complete sections of the Addenda as indicated.**

 ii) Please state the number of Operating Theaters:

|  |  |
| --- | --- |
|  |  |

12. Please give details of any procedure(s) performed at any Out Patient Clinic(s) which is / are NOT included in the above information or set out in a separate proposal form. Please specify the approximate number of patients treated and percentage of Gross Fee Income / Turnover / Gross Receipts derived during the past financial year:

|  |  |  |  |
| --- | --- | --- | --- |
|  | PATIENTSPER ANNUM |  | % OF TOTAL INCOME |

|  |  |  |  |
| --- | --- | --- | --- |
| Antenatal Clinic |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Assisted Conception  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Dental |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Elective Cosmetic |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Elective T.O.P. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| HIV/HEP(inc Counseling) |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Laser Eye Surgery |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Nutrition/Diet/Slimming |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| S.T.D. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Sports Injury |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Well Man |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Well Woman |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Other Medical \* |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Total |  |  |  |

 (\*) please give details

|  |
| --- |
|  |
|  |
|  |
|  |

13. **PLEASE NOTE THAT THIS POLICY IS DESIGNED TO COVER CLAIMS MADE AGAINST THE INSURED.** IF COVER IS ALSO REQUIRED FOR CLAIMS MADE AGAINST REGISTERED MEDICAL PRACTITIONERS FOR WORK PERFORMED AT THE INSURED, PLEASE SUPPLY A LIST OF ALL DOCTORS FOR WHOM COVERAGE IS REQUIRED STATING THE NAME, D.O.B., QUALIFICATIONS AND PRACTICE OF EACH DOCTOR. IN ADDITION TO THIS PLEASE CONFIRM WHETHER OR NOT THE DOCTORS ARE EMPLOYED BY THE INSURED OR SELF-EMPLOYED.

Please state the total number of persons involved in the following capacities:

|  |  |  |
| --- | --- | --- |
|  | **EMPOLYED BY ESTABLISHMENT** | **SELF EMPLOYED** |

|  |  |  |  |
| --- | --- | --- | --- |
| Non procedural Physicians:  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Psychiatrists |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Other  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Surgeons: |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Cosmetic |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Orthopaedic  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Other |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Anaesthetists  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Obstetricians |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Gynaecologists  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Lab/Path technicians |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Dentists  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Midwives |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Nurse Practitioners |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Nurses - Day  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Nurses-Night |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacists |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Paramedics  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Residential Medical Officers |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Complementary Professionals |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Supplementary Professionals |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Auxiliaries – Qualified  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Auxiliaries- Non Qualified  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Directors/Partners/Principals |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Clerical/Administration |  |  |  |

|  |
| --- |
| Other (please specify)  |

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

14. Do you ensure and record that all times Registered Medical and Dental Practitioners are members of a Medical / Dental Defence Organization, recognized by your National Medical / Dental Association, or are otherwise fully Insured for their own Malpractice?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 **If the answer is ‘NO’ refer to the NOTE in Question13.**

15. Are any counseling services made available to patients?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

If ‘YES’

 i) Please indicate in which of the following categories

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Number of Counselors** |  | **Employed** |  | **Self Employed** |  | **Number of Patients** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Assisted Conception |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Drug/Alcohol Dependency |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Elective Cosmetic |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Elective T.O.P. |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Gender Reassignment  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| HIV/HEP/STD |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sterilization  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Other (please specify)  |  |
|  |
|  |
|  |

 ii) Do all Counsellors hold appropriate qualifications?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |
| Please provide details |  |
|  |
|  |
|  |

16. Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e Hepatitis, H.I.V. etc. or other impediment which may affect the performance of his / her professional duties or places patients / clients at risk?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘YES’ what procedures are in place:

|  |
| --- |
|  |
|  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

17. i) Do you have a blood bank?

 ii) Please state average number of units of blood or blood products used by your Establishment in any one calendar month:

|  |
| --- |
|  |

 iii) Is 100% of the above brought or obtained from your National Blood Transfusion Service or National Red Cross?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘No’ please give full details:

|  |
| --- |
|  |
|  |
|  |

 iv) Are all blood and blood products tested for transmittable diseases in accordance with the National Blood Transfusion Service, National Red Cross Society or an equivalent body prior to use?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘YES’ please list all tests carried out:

|  |
| --- |
|  |
|  |
|  |

 If ‘NO’ please give full details:

|  |
| --- |
|  |
|  |
|  |

 Please provide full details of storage facilities and procedures:

|  |
| --- |
|  |
|  |
|  |

18. Please give full details of what records are kept, where and how they are stored and fo hoe long they are retained.:

|  |
| --- |
|  |
|  |
|  |

 **Please note that 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**

19. i) Do you provide facilities for the sterilization of instruments in accordance with current guidelines?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘NO’ please provide details o what arrangements are in place for this :

|  |
| --- |
|  |
|  |
|  |

 If ‘YES’ do you ensure that effective cross-infection control methods are employed?

|  |
| --- |
|  |
|  |
|  |

 ii) Do you have a protocol for needlestick injuries?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘No’ please give full details:

|  |
| --- |
|  |
|  |
|  |

|  |
| --- |
| **PREVIOUS INSURANCE HISTORY** |

**PLEASE REFER TO BROKER / INSURANCE AGENT IF YOU ARE IN ANY DOUBT AS TO WHAT IS BEING ASKED OF YOU IN THIS SECTION.**

20. i) Who are the present Medical Professional Underwriters of the insured?

|  |
| --- |
|  |
|  |

 ii) Has prior coverage been n CLAIMS MADE BASIS?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 iii) If ‘YES’ what is the retroactive date?

|  |
| --- |
|  |
|  |

 iv) What are the present policy limits of insurance?

|  |
| --- |
|  |
|  |

 v) What is the amount of self insured excess for each policy?

|  |
| --- |
|  |
|  |

 vi) What is the expiry date of the present policies?

|  |
| --- |
|  |
|  |

21. Has any application for this type of insurance cover ever been:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| i) Declined? | YES |  |  | NO |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ii) Cancelled? | YES |  |  | NO |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| iii) Required special terms? | YES |  |  | NO |  |

 If the answer of any of the above is ‘YES’ please give details:

|  |
| --- |
|  |
|  |

|  |
| --- |
| **PREVIOUS CLAIMS HISTORY** |

22. i) List all claims made against the Insured during the last 10 years for both Medical Professional and Public Liability, including any made against the Insured even if cover was not previously purchased. **IF NONE, PLEASE STATE “NONE”:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of incident | Date of Claim | Amount claimed | Amount Paid | Amount outstanding | Details including nature of the allegations details of claimant  |
|  |  |  |  |  |  |

 **ii)** List all circumstances / complaints during the last 10 years for both Medical Professional and Public Liability, which may give rise to a claim being made against the Insured even if cover was not previously purchased. **IF NONE, PLEASE STATE “NONE”:**

|  |  |
| --- | --- |
| Date of Circumstance  | Detail including nature of the Complaint and details of the Compliant  |
|  |  |

**23.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| i) Have all of the above in question 22 been notified to your previous underwriters? | YES |  |  | NO |  |
|  |
| ii) Have all of the above been accepted by your previous Underwriters? | YES |  |  | NO |  |

**24.** Please indicate with limit(s) of indemnity you require quotation for:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 million  |  | 2 million |  | 3 million |  | 4 million |  | 5 million |  | Other |

I / We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever has been withheld which 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 as soon as practicable. 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 voiding 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 BEHLAF OF |  |
|  | NAME OF INSURED |

|  |  |  |  |
| --- | --- | --- | --- |
| SIGNATURE |  | DATED |  |

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF PROPOSER |  | POSITION |  |

|  |  |
| --- | --- |
|  | (IN BLOCK CAPITALS) |

|  |
| --- |
| **ADDENDUM 1 – ASSISTED CONCEPT** |

1. If an Assisted Conception unit is maintained, please give a full percentage breakdown of the number of cycles undertaken:

|  |  |
| --- | --- |
| A.I.H. |  |

|  |  |
| --- | --- |
| A.I.D. |  |

|  |  |
| --- | --- |
| I.V.F./E.T./P.R.O.S.T. |  |

|  |  |
| --- | --- |
| Frozen Embryo Replacement |  |

|  |  |
| --- | --- |
| G.I.T.F. |  |

Others (please specify an indicate numbers)

|  |
| --- |
|  |

Are counseling services made available to patients?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

2. Is all donor semen screened, cryopreserved and quarantined in line with current recommendations?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

|  |
| --- |
| **ADDENDUM 2 – CLINICAL TRIALS**  |

1. Please state for whom Clinical Research Projects are undertaken e.g. Pharmaceutical and other Manufacturers, Charities, Research Foundations.

|  |
| --- |
|  |

2. Do you receive a full indemnity from your Principals?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

3. Do all volunteers sign an Informed Consent Form?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

4. If Double Blind studies are undertaken are volunteers made full aware of this?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

5. Do any trials involve any female volunteer of child-bearing age?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

 If ‘YES’ please provide full details:

|  |
| --- |
|  |

6. Please state the Annual Income of Turnover;

|  |
| --- |
|  |

7. Please state the number of trials during the list 12 months detailing the number of volunteers in each trial:

|  |
| --- |
|  |

8. Please state the anticipated number of trials with which you will b involved during the next 12 months detailing the number of volunteers in each trial:

|  |
| --- |
|  |

9. Do you conduct any formal research, testing or experimental activities in the following categories:

|  |  |
| --- | --- |
| Transplant  | Human Embryo research  |
| Surgery  | Art |
| Obstetrics | Genetic Engineering  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

If ‘YES’ please attach full details

**Please provide a copy of your Volunteer Informed Consent Form and any indemnity referred to in question 2 above**.

|  |
| --- |
| **ADDENDUM 3 – MATERNITY / OBSTETRICS**  |

1. Please state the number of Deliveries per annum

|  |  |
| --- | --- |
|  |  |

|  |  |
| --- | --- |
| Including: Multiple Births |  |

|  |  |  |
| --- | --- | --- |
|  | Healthy Neonatals  |  |

|  |  |  |
| --- | --- | --- |
|  | Stillborn Infants  |  |

|  |  |
| --- | --- |
| Infants delivered at less than 32 weeks gestation: |  |

|  |  |
| --- | --- |
| Infants delivered at less than 1501 grammes |  |

|  |  |
| --- | --- |
| Infants with an Apgar rate of less than 6 at five minutes: |  |
|  |

|  |  |
| --- | --- |
| Number of infants admitted to the NICU / SCBU |  |

|  |  |
| --- | --- |
| i)from your own Obstetrical Department: |  |

|  |  |
| --- | --- |
| ii) transferred from entities outside the control of the Proposer |  |
|  |

2. Is an Obstetrician available ‘in-house’ 24 hours per day?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

3. Is a second Obstetrician on call 24 hours per day who is able to attend within 30 minutes?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

4. Is a Paediatrician available in-house 24 hours per day?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

5. Is an Anaesthetist available solely to the obstetrical department 24 hours a day?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

6. Is a second Anaesthetist on call 24 hours per day who is able to attend within 30 minutes?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

7. Can emergency Caesarean sections be performed within 30 minutes 24 hours per day?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

8. Can Midwives attend births without an attending Doctor?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

9. Can outside Doctors attend their own patients?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

10. Please give brief details of the Proposer’s policy in respect of mother and foetal monitoring:

|  |
| --- |
|  |
|  |
|  |

11. Do you offer counseling service for parents following miscarriage, or perinatal death, or the birth of handicapped children?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| YES |  |  | NO |  |

|  |
| --- |
| **ADDENDUM 4 – ELECTIVE T.O.P.** |

1. If elective T.O.P.’s are undertaken, please provide a full breakdown of the number of procedures by gestation period at time of termination.

|  |  |
| --- | --- |
| Up to 12 weeks |  |

|  |  |
| --- | --- |
| 12 to 16 weeks |  |

|  |  |
| --- | --- |
| 16 to 20 weeks |  |

|  |  |
| --- | --- |
| 20 to 24 weeks |  |

|  |  |
| --- | --- |
| Over 24 weeks |  |

|  |
| --- |
| **ADDENDUM 5 – EMERGENCY CARE** |

 Please

 Tick Box

1. Please indicate which of the following best

describes the extent of emergency care provided by the Insured:

|  |  |
| --- | --- |
| i)Comprehensive emergency care is available 24 hours a day and includes anaesthetic, medical and surgical services by resident medical staff, with other speciality consultation available within approximately 30 minutes. |  |
|  |
|  |
|  |
|  |  |
| ii)A Doctor is always present in the emergency care area with speciality consultation available within approximately 30 minutes. |  |
|  |
|  |
|  |  |
| iii)Emergency care is provided with approximately 30 minutes through a medical staff call roster. |  |
|  |
|  |

If none of the above, please provide full details.

**PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE APPROPRIATE QUESTION NUMBER.**