PRIME INSURANCE COMPANY LIMITED

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PROFESSIONAL INDEMNITY PROPOSAL

MEDICAL ESTABLISHMENT ERRORS & OMISSIONS INSURANCE

(Hospitals, Clinics, Nursing Homes, Old Aged Homes and the like)

IMPORTANT NOTICE

THIS FORM MAY BE USED FOR RENEWALS OR NEW BUSINESS. IN THE CASE OF RENEWALS, THE COMPLETED FORM MUST BE RECEIVED BY THE UNDERWRITERS, AND ACCEPTANCE OF THE RENEWAL TERMS ADVISED TO THEM PRIOR TO RENEWAL DATE, FAILING WHICH NO COVER EXISTS AFTER SUCH DATE.
PLEASE ANSWER **ALL** QUESTION FULLY. IF THE SPACE PROVIDED IS INSUFFICIENT, A SEPARATE SHEET SHOULD BE ATTACHED.

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1. a) Full name of Establishment:

   ....

   b) Establishment is owned by:

   ....

   c) What percentage of shares in ownership is held by U.S.A. interests?

   ....

   d) How long has the Establishment been operated by present owners?

   ....

   e) Is the Establishment registered as a charity? YES ☐ NO ☐

   If Yes, what is the approximate percentage of charity patients?

   ....

2. a) The principal address of the Establishment:

   ....

b) If other locations are to be protected, list them hereunder or state "NONE".

1. ....

2. ....

3. ....

3. Give the full name, qualification and years of experience of the Administrator:

....

....

4. Is the Establishment licensed to operate at the address declared under 2. above? YES ☐ NO ☐

5. What is the total annual income to the Establishment and its concomitant clinics and units?

R ....

6. Give a brief description of the Proposer's activities (e.g. operation of a hospital, nursing home, sanatorium).

……………………………………………………………………………………………………

……………………………………………………………………………………………………

7. State the approximate split of in-patient throughput between the following:

Psychiatric	.... %	Neuro Surgical	.... %
Drug/Alcoholic	.... %	Cardiac Surgical	.... %
Geriatric	.... %	Elective Cosmetic Surgical	.... %
Communicable Diseases	.... %	Other Surgical	.... %
Elective Terminations	.... %	Paediatric	.... %
Other OB/GYN	.... %	General	.... %

8. Does the Establishment have:

a) an I.C.U.? YES ☐ NO ☐

b) a Casualty Department? YES ☐ NO ☐

c) a Radiotherapy Unit? YES ☐ NO ☐

d) a Medical Teaching Facility? YES ☐ NO ☐

9. a) How many patient beds are available? ....

b) What is the approximate annual occupancy? ....

10. How many of the following are on the payroll?

a) Surgeons (not consultants),
Surgical Registrars ....

b) Physicians, Registrars, Housemen ....

c) SRN, SCM, SEN ....

11. Do you have any of the following on your payroll?

1. Obstetricians YES ☐ NO ☐

2. Gynaecologists YES ☐ NO ☐

3. Anaesthetists YES ☐ NO ☐

4. Neuro-Surgeons YES ☐ NO ☐

5. Plastic Surgeons YES ☐ NO ☐

6. Orthopaedic Surgeons YES ☐ NO ☐

7. Other Specialists YES ☐ NO ☐

PLEASE NOTE

No cover will be provided, in terms of the Policy, for these occupations.

12. Has the Establishment a Nurses Training School?

YES ☐ NO ☐

13. List Clinics operated and approximate patient numbers per annum:

e.g. Birth Control .... per annum

Varicose Veins .... per annum

V.D. .... per annum

.... per annum

14. Is there any blood banking facility?

YES ☐ NO ☐

If Yes, please state:

a) Percentage of blood purchased .... collected ....

b) Approximate total number of pints per annum ....

c) Approximate number of plasmapheresis procedures carried out annually ....

d) Estimate the annual gross receipts from the sale of the following per annum:

i) Whole Blood ....

ii) Blood Plasma ....

iii) Serum ....

iv) Other blood products or derivatives ....

15. Give full details of:

a) The screening of persons from whom blood or plasma is drawn.

....

....

b) The screening of the products (i) to (iv) above prior to their sale, use or disposal.

....

....

16. Please give details of any claims settled or outstanding or compromise settlements arising from any breach of duty whether insured or not.

....

....

....

17. Is the Proposer aware of any circumstances which may give rise to a claim?

YES ☐ NO ☐

If Yes, please give full details.

....

....

....

18. Has the Establishment previously been insured for Medical Malpractice Liability? YES ☐ NO ☐

If Yes, please state:

i) Name of Insurers

....

ii) Indemnity Limit MK ....

iii) Deductible MK ....

iv) Expiry date of cover ....

19. Quotations required:

a) Limit of Indemnity (annual aggregate, inclusive of costs)

MK ....

b) Excess per claim

MK ....

c) Is cover required for Retroactive Errors and Omissions? YES ☐ NO ☐

If Yes, please state period of cover required:

....

20. If Premises Liability Cover is required:

a) When was the Establishment built?

....

b) Are the main buildings of fire-proof construction? YES ☐ NO ☐

c) Are the lifts/escalators regularly serviced under contract? YES ☐ NO ☐

d) Are non-slip polishes used on all uncarpeted floors, passageways and staircases? YES ☐ NO ☐

e) What distance is the nearest fire brigade? ....KM

f) Are nursing staff instructed in fire control and escape procedures? YES ☐ NO ☐

DECLARATION

WE HEREBY DECLARE that the above statements and particulars are true and complete to the best of our knowledge and that we have not suppressed or misstated any material facts, and we agree that this application shall be the basis of any contract* subsequently effected between the Establishment and the Insurers.

....

DATE

SIGNATURE OF ADMINISTRATOR
ON BEHALF OF THE ESTABLISHMENT

* 1. Completion and signature of this Proposal Form does not bind the Establishment or the Underwriters to complete this insurance.

2. If a policy is concluded it will be issued on a 'CLAIMS MADE' basis, i.e. to indemnify the Establishment for claims first made against it in the manner described in the Policy during the Policy Period.