|  |  |  |  |
| --- | --- | --- | --- |
| **Which sections should you complete?** | Section | Title | Should you complete it? |
| 1. | Your organisation | **All organisations must complete this section** |
| 2. | Subsidiary and associated companies | Please complete this section if you require cover under any section of cover for subsidiary or associated companies |
| 3. | Medical malpractice | **All organisations must complete this section** |
|  | 4. | Care homes | Please complete this section if your organisation is a care home |
|  | 5. | Medical establishments | Please complete this section if your organization is a medical establishment |
|  | 6. | Claims | **All organisations must complete this section** |
|  | 7. | Declaration | **All organisations must complete this section** |
|  |  |  |  |
| This proposal form | In deciding whether to accept the insurance and in setting the terms and premium, we have relied on the information you have given us.You must:  |
|  |  | give a fair presentation of the risk to be insured by clearly disclosing all material facts and circumstances (whether or not subject to a specific question) which you, yoursenior management and those responsible for arranging this insurance, know or ought to know following a reasonable search;   |
|  |  | take care by ensuring that all information provided is correct, accurate and complete. |

|  |  |
| --- | --- |
| **Section 1 - Your organisation** | **You must complete this section.**  |
| 1.1 Your organisation | Business name |       |
|  |
|  | Main address |       |
|  |
|  | Post code |       |  |
|  |
|  | Date business established |   /  /     |
|  |
|  | Type of organisation |       |
|  |  |  |
| 1.2 Your employees | Your total number of employees (including subsidiaries)  |       |
|  |
| 1.3 Subsidiary or associated companies | Do you require cover (under any section to be insured) for any subsidiary or associated companies? | Yes [ ]  No [ ]  |
|  | If **Yes**, you must ensure that all other information you give in this proposal form incorporates that for the subsidiary or associated companies, including income and claims information.You must also complete **section 2** **– Subsidiary and associated companies**. |
|  |  |
| 1.4 Additional liabilities | Is cover required for anything other than work undertaken by the firm(s) identified on this proposal form? This may include a predecessor in business or liability of one of your partners or principals relating to work undertaken elsewhere. | Yes [ ]  No [ ]  |
|  | If **Yes**, please provide details: |
|  |       |
|  |
| 1.5 Your income | Your income for the last completed financial year or if you have not completed your first financial year, your expected annual income |       |
|  |
| Please provide a breakdown of your income according to the regions and legal jurisdiction of your contracts: |
|
| Region | Percentage split by location where the contracts are undertaken | Percentage split by the jurisdiction applying to your contracts |
| United Kingdom (UK)  |  |  |
| Republic of Ireland (IRE) |  |  |
| European Union (excluding UK/IRE)  |  |  |
| USA and Canada |  |  |
|  | Rest of the world |  |  |
|  | **Total** | 100% | 100% |
|  |
|  | If your income is expected to significantly change in your next financial year, please provide an estimate and any supporting details:  |
|  |       |
|  |

|  |
| --- |
| Location of business income & activitiesHave you ever or do you plan to: work or contract with; or make any payments to, any person, entity or organisation that is domiciled in or operates in any way from; or travel to the following countries, |
| ☐ No ☐ Yes, please select, |
| ☐ Afghanistan, ☐ Belarus, ☐ Cuba, ☐ Iran, ☐ Myanmar, ☐ North Korea, ☐ Russia, ☐ Syria, ☐ non-Government controlled areas of Ukraine, ☐ Venezuela |
| 1.6 Patients and clients | Your total number of patients and clients in the last financial year |        |
|  |
| 1.7 Your experience | How many years of relevant experience do you have? |       |
|  | If less than five years, please provide CV’s for all principals |
|  |
| 1.8 Locations | How many locations do you operate from? |        |
|  |
| 1.9 Registration | Are you registered and licensed to practice in accordance with the appropriate regulatory body i.e. Care Quality Commission? | Yes [ ]  No [ ]  |
|  |  |  |
|  | Please give details of the professional bodies, or licensing authorities you are registered with: |
|  |       |
|  |
|  | Has any such registration/membership ever been suspended or withdrawn? | Yes [ ]  No [ ]  |
|  |  |  |
|  | If Yes, please give details on a separate sheet. |  |

|  |  |
| --- | --- |
| **Section 2 -Subsidiary or associated companies** | **Please complete this section if you require cover under any section of cover for subsidiary or associated companies.** |
| We can extend this insurance to include subsidiary or associated companies for which you require cover provided that: |
| a. | a complete list of the companies is given below (or on a separate sheet if necessary); and |
|  | b. | the turnover and claims information declared on this proposal form incorporates that for the subsidiary or associated companies; and |
|  | c. | all other information you give in this proposal form incorporates that for the subsidiary or associated companies. |
|  |  |  |
| 2.1 Subsidiary companies | Subsidiary company means any company in which the company named in section 1, directly or indirectly, owns more than 50% of the book value of the assets or outstanding voting rights.Please provide the following details for all subsidiary companies to be insured. |
|  | Name | Main/registered address including postcode | Country | HMRC Employer Reference Number^ |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |       |       |       |       |
|  |       |       |       |       |
|  |       |       |       |       |
|  |  |  |  |  |
| 2.2 Associated companies | Please provide the following details for any associated companies to be insured below: |
|  | Name | Main/registered address including postcode | Country | HMRC Employer Reference Number^ |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |       |       |       |       |
|  |  |
| 2.3 ERN information | ^The HMRC Employer Reference Number (ERN) is required if you wish to be insured for employers’ liability (see section 5.6). The ERN is also referred to as the ‘Employer PAYE reference’ on HMRC documentation. It always starts with three digits, followed by a slash (‘/’), then a string of letters and numbers.If the company or entity does not have an ERN, please enter the reason in the relevant box above, which should be one of the following: |
|  | a. | the business does not have any employees |
|  | b. | the business is registered outside England, Scotland, Wales or Northern Ireland |
|  | c. | all employees earn below the current PAYE threshold |

|  |  |
| --- | --- |
| **Section 3 – Medical malpractice** | **You must complete this section** |
| 3.1 Business activities | Please provide a full description of your business activities for which cover is required: |
|  |  |
|  |       |
|  |  |  |
| 3.2 Contracts and jurisdiction | a. | Do you work under normal contract conditions? | Yes [ ]  No [ ]  |
|  | If **No**, please supply details on a separate sheet. |
|  |
|  | b. | Do you accept liability other than under the jurisdiction of the UK courts?  | Yes [ ]  No [ ]  |
|  |
| 3.3 Professional persons | a. | Please state the number of persons involved in the following professions: |
|  |  |  |
|  |  | Employed | Self employed |  | Employed | Self employed |
|  | Anesthetist |       |       | Nurse |       |       |
|  | Audiologist |       |       | Nutritionist |       |       |
|  | Auxiliary nurse |       |       | Occupational therapist |       |       |
|  | Beautician |       |       | Obstetrician |       |       |
|  | Cardiology |       |       | Optometrist/optician |       |       |
|  | Chiropodist |       |       | Osteopath |       |       |
|  | Chiropractor |       |       | Orthopedics |       |       |
|  | Complementary practitioner |       |       | Pediatrician |       |       |
|  | Dermatologist |       |       | Paramedic |       |       |
|  | Dentistry |       |       | Pathology |       |       |
|  | Dietician |       |       | Pharmacist |       |       |
|  | Domiciliary carer |       |       | Physiotherapist |       |       |
|  | Doctor (GP) |       |       | Psychiatrist |       |       |
|  | First aider  |       |       | Podiatrist |       |       |
|  | Gynecologist |       |       | Radiotherapist |       |       |
|  | Haematologist |       |       | Social worker |       |       |
|  | Midwife |       |       | Surgeon |       |       |
|  | Other - please specify |       |       |       |
|  |
|  | b. | Are all registered medical and dental practitioners members of a medical or dental defence organisation, or otherwise fully Insured for their own malpractice, and do you retain records to ensure this? | Yes [ ]  No [ ]  |
|  |
|  | c. | Do you, and anyone who carries out work on your behalf, hold a recognised professional qualification and have relevant experience to undertake your activities?  | Yes [ ]  No [ ]  |
|  |  |  |  |
|  | If **No** to either b or c., please supply details on a separate sheet. |

|  |  |  |
| --- | --- | --- |
|  | d. | Please state relevant qualifications and experience of key members of staff continue on a separate sheet if necessary  |
|  |
|  | Staff member | Qualifications |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  |  |  |
| 3.4 Client records | Please confirm the number of years for which you keep client records and details of the services you provide:  |       |
|  |
| 3.5 Sub-contractors | Do you use sub-contractors or consultants? | Yes [ ]  No [ ]  |
|  |
|  | If **Yes**: |
|  | a. | How much have you paid to them in the last 12months? |        |
|  |
|  | b. | For which work are they used? |  |
|  |  |       |
|  |
|  | c. | Do all subcontractors hold malpractice insurance? | Yes [ ]  No [ ]  |
|  |
|  | d. | Do you ensure they have qualifications and experience relevant to the work they undertake? | Yes [ ]  No [ ]  |
|  |
| 3.6 Previous insurance | Have you ever bought medical malpractice insurance in the past? | Yes [ ]  No [ ]  |
|  | If **Yes**, please provide details of your most recent policy: |  |
|  | Name of insurer | Limit of indemnity | Excess | Premium | Renewal date | No. of years continuously held |
|  |       |       |       |       |       |       |
|  |  |
|  |  | Retroactive date (if applicable): |     /    /      |
|  |  |
| 3.7 Cover required | Limit of indemnity required: |
|  |
|  | £1,000,000 [ ]  | £2,000,000 [ ]  | £5,000,000 [ ]  | Other: | £       |

|  |  |
| --- | --- |
| **Section 4 – Care homes** | **Optional – only complete this section if your business is a care home.** |
| 4.1 Capacity | Total number of beds: |        |
|  |
|  | Please provide details of:  |  |  |  |
|  |  | 0-4 yrs | 5-10 yrs | 10-18 yrs |
|  | Total number of males |       |       |       |
|  | Total number of females |       |       |       |
|  | Total number of bedrooms |       |       |       |
|  | Number of children per room |       |       |       |
|  | Segregation arrangements |       |       |       |
|  |
| 4.2 Type of home | Please state what type of home you operate i.e. geriatric, convalescent, hospice etc: |
|  |       |
|  |
| 4.3 Activity split | Please provide a split of your activities between: |
|  | Administering pre-prescribed medication |        % |
|  | Assistance with cooking or cleaning |        % |
|  | Care for individuals with learning disabilities |        % |
|  | Care for individuals with physical disabilities |        % |
|  | Geriatric care |        % |
|  | Personal and domestic care |        % |
|  | Terminal illness care |        % |
|  | Other |        % |
|  |  |
| 4.4 Patient numbers | Total number of patients last year |         |
|  |
|  | Total number of patients anticipated for the forthcoming year |        |
|  |
| 4.5 Policies | Do you have protocols in place for: |
|  | Drug administration? | Yes [ ]  No [ ]  |
|  |
|  | Behavioral management?  | Yes [ ]  No [ ]  |
|  |
|  | Restraint?  | Yes [ ]  No [ ]  |
|  |
|  | Do you, and anyone who carries out work on your behalf, have procedures in place for drug administration, behavioral management and restraint? | Yes [ ]  No [ ]  |
|  |
|  | If **No**, please supply information on a separate sheet. |
|  |
| 4.6 Previous care work | Have you, or anyone who carries out work on your behalf, ever undertaken care for:  |  |
|  | children who have been sexually abused? | Yes [ ]  No [ ]  |
|  |
|  | patients with acquired brain injuries? | Yes [ ]  No [ ]  |
|  |
|  | patients sectioned under the mental health act? | Yes [ ]  No [ ]  |
|  |
|  | If **Yes**, please supply information on a separate sheet. |
|  |

|  |  |
| --- | --- |
| 4.7 Care Quality Commission | Please provide the latest Care Quality Commision (CQC) report for your home. |
|  |
|  | Has CQC registration ever been cancelled conditions imposed? | Yes [ ]  No [ ]  |
|  |
|  | Were any recommendations made in your most recent CQC report? | Yes [ ]  No [ ]  |
|  |
|  | If **Yes**, please give details: |
|  |       |
|  |
| 4.8 Disclosure barring service  | Are you, and anyone who carries out work on your behalf, approved by the Disclosure Barring Service (DBS)? | Yes [ ]  No [ ]  |
|  |
| 4.9 Qualifications for invasive treatments | Are all staff who carry out any care activities qualified to at least NVQ level 2 (in health and social care), and level 3 for those undertaking invasive treatments e.g. PEG feeding? | Yes [ ]  No [ ]  |

|  |  |
| --- | --- |
| **Section 5 – Medical establishments** | **Optional – only complete this section if your organisation is a medical establishment.** |
| 5.1 Facilities | Does the facility have: |  |
|  | M.R.I /C.A.T./P.E.T. scanners or similar?  | Yes [ ]  No [ ]  |
|  |
|  | Medical teaching facilities? | Yes [ ]  No [ ]  |
|  |
|  | Pathology facilities? | Yes [ ]  No [ ]  |
|  |
|  | Please state: |  |
|  | Number of beds: | Inpatients |       | Outpatients |       |
|  |
|  | Percentage of daily occupancy:  |       |
|  |
|  | Total number beds: |       |
|  |
| 5.2 Use of instruments | a. | Do you, and anyone who carries out work on your behalf, always handle, use, sterilise and store all instruments in accordance with manufacturer’s instructions? | Yes [ ]  No [ ]  |
|  |
|  | b. | If you do not have in house sterilisation facilities, please state what arrangements are made: |
|  |
|  |       |
|  |
| 5.3 Needle stick injury | Do you operate a needle stick injury policy? | Yes [ ]  No [ ]  |
|  | If **Yes**, please supply a copy |  |
|  |
| 5.4 Records | Please give details of what patient records are kept and how long they are retained: |
|  |       |
|  | (Please note records must be retained ten years, and in the case of minors, ten years from the date of majority). |

|  |  |
| --- | --- |
| **Section 6 - Claims** | **You must complete this section. Please complete the claims questions for any risk now to be insured.**  |
| 6.1 General | In relation to your professional business activities, are you after reasonable enquiry aware of: |
|  | a. | any matter which may lead to a claim against you. |
|  |  | This includes: |
|  |  | i. | a shortcoming or problem in your work known to you which you cannot reasonably put right; | Yes [ ]  No [ ]  |
|  |  | ii. | a complaint about your work or anything you have supplied which cannot be immediately resolved; | Yes [ ]  No [ ]  |
|  |  | iii. | an escalating level of complaint on a particular project; | Yes [ ]  No [ ]  |
|  |  | iv. | a client withholding payment due to you after any complaint. | Yes [ ]  No [ ]  |
|  | b. | any loss from the dishonesty or malice of any employee or self-employed freelancer. | Yes [ ]  No [ ]  |
|  | c. | any loss from the suspected dishonesty or malice of any employee or self-employed freelancer. | Yes [ ]  No [ ]  |
|  | d. | any matter which may give rise to a claim against your predecessors in business or any past director, officer, board member, senior manager or employee. | Yes [ ]  No [ ]  |
|  | If you answered **Yes** to any of the above, please provide full details: |
|  |       |
|  |  |
| 6.2 Your directors and partners | a.  | Have you or any of your directors or partners at any time either personally or in any business capacity ever been made bankrupt or insolvent either in a personal capacity or in connection with a business liability? | Yes [ ]  No [ ]  |
|  | b. | Have you (or any fellow director or business partner) ever been convicted of or charged with a criminal offence other than a conviction spent under the Rehabilitation of Offenders Act 1974? | Yes [ ]  No [ ]  |
|  | If **Yes**, please give full details on a separate sheet. |
|  |  |
| 6.3 Medical Malpractice | In respect of medical malpractice and treatments: |  |
|  | a. | are you aware of any shortcoming, fact or problem which may give rise to a claim? | Yes [ ]  No [ ]  |
|  | b. | are you aware of any complaints about your work or anything you have supplied? | Yes [ ]  No [ ]  |
|  | c.  | has any claim or loss, whether successful or not, ever occurred or been made against you or your predecessors in business or any past or present director, officer, board member, senior manager or employee in respect of any risk now to be insured under the insurance covers listed above (whether previously insured or not)? | Yes [ ]  No [ ]  |
|  | If **Yes**, please give full details on a separate sheet. |  |
|  |  |
| 6.4 Professional bodies | Have you or anyone that works for your business ever been the subject of disciplinary proceedings by any professional organisation? | Yes [ ]  No [ ]  |
|  | If Yes, please give full details on a separate sheet. |  |

|  |  |
| --- | --- |
| **Section 7 -Declaration** | **You must complete this section.****Please read the declaration carefully and sign at the bottom.** |
| 7.1 Material information | Please provide us with details of any information which may be relevant to our consideration of your proposal for insurance. If you have any doubt over whether something is relevant, please let us have details. |
|  |  |
|  | Is there anything else that you would like to tell us about you or your business? | Yes [ ]  No [ ]  |
|  |       |
|  |  |
| 7.2 Using your personal information | Hiscox is a trading name of a number of Hiscox companies. The specific company acting as a data controller of your personal information will be listed in the documentation we provide to you. If you are unsure you can also contact us at any time by telephoning 01904 681198 or by emailing us at dataprotectionofficer@hiscox.com.We collect and process information about you in order to provide insurance policies and to process claims. Your information is also used for business purposes such as fraud prevention and detection and financial management. This may involve sharing your information with, and obtaining information about you from, our group companies and third parties such as brokers, loss adjusters, credit reference agencies, service providers, professional advisors, our regulators or fraud prevention agencies.We may record telephone calls to help us monitor and improve the service we provide.For further information on how your information is used and your rights in relation to your information please see our privacy policy at www.hiscox.co.uk/cookies-privacy. |
|  |  |
| 7.3 Declaration | I/we confirm that the information given in this proposal form is correct, accurate and complete and I have made a fair presentation of the risk. |
|  |  |
|  |       |
|  | Name of director/officer/board member/senior manager |
|  |  |
|  |  |  |  |
|  |  |  |
|  |  |   /  /     |
|  | Signature of director/officer/board member/senior manager |  | Date |
|  |  |
|  | **A copy of this proposal should be retained for your records.** |
|  |  |
| 7.4 Complaints | Hiscox aims to ensure that all aspects of your insurance are dealt with promptly, efficiently and fairly. At all times Hiscox are committed to providing you with the highest standard of service. If you have any concerns about your policy or you are dissatisfied about the handling of a claim and wish to complain you should, in the first instance, contact Hiscox Customer Relations in writing at:Hiscox Customer RelationsThe Hiscox BuildingPeasholme GreenYork YO1 7PR by telephone on 0800 116 4627/01904 681 198 or by email at customer.relations@hiscox.com.Where you are not satisfied with the final response from Hiscox, you also have the right to refer your complaint to the Financial Ombudsman Service. For more information regarding the scope of the Financial Ombudsman Service, please refer to www.financial-ombudsman.org.uk. |