|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. | | Claims | **All organisations must complete this section** |
|  | 5. | | 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. | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 (excluding sale of goods) or if you have not completed your first financial year, your expected annual income (excluding sale of goods) | | | | | | |  | |
|  | | | | | | | | |
| 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 & activities  Have 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? | | | | | | | | |  |

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| --- | --- | --- | --- | --- | --- |
| **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^ |
|  | |  |  |  |
|  | |  |  |  |
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|  |  | |  |  |  |
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|  |  | |  |  |  |
| 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 | | | |

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| **Section 3 – Medical malpractice** | | **You must complete this section** | | | | | | | | | | |
| 3.1 Treatments and procedures | Please provide details on the procedures you provide: | | | | | | | | | | | |
|  | Treatment | | | | Product or system used | | | Name of practitioners providing treatment | | | | |
|  | Botox | | | |  | | |  | | | | |
|  | Chemical peel – superficial peels excluding TCA | | | |  | | |  | | | | |
|  | Chemical peel – medium peels using TCA up to 40% | | | |  | | |  | | | | |
|  | Chemical peel – deep peels using Phenol or TCA over 40% | | | |  | | |  | | | | |
|  | Carboxytherapy | | | |  | | |  | | | | |
|  | Colonic hydrotherapy | | | |  | | |  | | | | |
|  | Dental block/local nerve infiltration | | | |  | | |  | | | | |
|  | Dermaroller/micro needling – 1.5mm | | | |  | | |  | | | | |
|  | Dermaroller/micro nendling – up to 2.5mm face and 3mm body | | | |  | | |  | | | | |
|  | Derma filler (temporary) | | | |  | | |  | | | | |
|  | Dermal fillers (semi permanent) sculptra, varioderm | | | |  | | |  | | | | |
|  | Hyperhydrosis – advanced botox training | | | |  | | |  | | | | |
|  | Laser hair removal (ablative – IPL,LHE)  Must be CE marked equipment  Skin type 1-4 | | | |  | | |  | | | | |
|  | Laser hair removal (ablative – IPL,LHE)  Must be CE marked equipment  Skin type 5-6 | | | |  | | |  | | | | |
|  | Laser rejuvenation (non ablative – IPL, LHE, LED)  Must be CE marked equipment  Skin type 1-4 | | | |  | | |  | | | | |
|  | Laser rejuvenation (non ablative – IPL, LHE, LED)  Must be CE marked equipment  Skin type 5-6 | | | |  | | |  | | | | |
|  | Laser tattoo removal – Q switched lasers only  Must be CE marked | | | |  | | |  | | | | |
|  | Laser thread vein, acne, skin firming | | | |  | | |  | | | | |
|  | Laser lipolysis   * Smart lipo deka * Osyris pharon * Vaser Lipo | | | |  | | |  | | | | |
|  | Macrolane | | | |  | | |  | | | | |
|  | Mesotherapy | | | |  | | |  | | | | |
|  | Microdermabrasion | | | |  | | |  | | | | |
|  | Platysmal bands – botox | | | |  | | |  | | | | |
|  | Radiofrequency body contouring (fat and cellulite reduction) | | | |  | | |  | | | | |
|  | Radio frequency skin tightening | | | |  | | |  | | | | |
|  | Removal of skin tags, milia and non malignant moles only | | | |  | | |  | | | | |
|  | Micro/sclerotherapy (non varicose) | | | |  | | |  | | | | |
|  | Semi permanent make-up/ Micropigmentaion | | | |  | | |  | | | | |
|  | Teeth whitening– hydrogen peroxide and carbamide peroxide treatments | | | |  | | |  | | | | |
|  | Teeth whitening – all other teeth whitening products | | | |  | | |  | | | | |
|  | Other treatments/procedures (please specify) | | | |  | | |  | | | | |
|  |  | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 3.2 Client records | | Please confirm the number of years for which you keep client records and details of the services you provide: | | | | | | | | |  | |
|  | | | | | | | | | | | | |
| 3.3 Medical defence organisation membership | | Are all professionally qualified staff, who do not require cover under this policy, 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 |
|  | | | | | | | | | | | | |
| 3.4 Regulatory bodies | | | Please give details of the professional bodies, or licensing authorities you are registered with: | | | | | | | | | |
|  | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| 3.5 Remote prescriptions | | | Do you provide remote prescription services for other practitioners? | | | | | | | Yes  No | | |
|  | | | | | | | | | | | | |
|  | | | If Yes, please confirm your income derived from this activity: | | | | | | | £ | | |
|  | | | | | | | | | | | | |
| 3.6 Photographs | | | Are photographs taken before and after first treatments? | | | | | | | Yes  No | | |
|  | | | | | | | | | | | | |
| 3.7 Staff | | | Name, position and professional qualification | Professional body membership | | Years of experience | Employed/self-employed | | Cover required under this policy | | | |
|  | | |  |  | |  |  | | Yes  No | | | |
|  | | |  |  | |  |  | | Yes  No | | | |
|  | | |  |  | |  |  | | Yes  No | | | |
|  | | |  |  | |  |  | | Yes  No | | | |
|  | | |  |  | |  |  | | Yes  No | | | |
|  | | |  |  | |  |  | | Yes  No | | | |
|  | | | Please continue on a separate page if necessary. | | | | | | | | | |
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| 3.8 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 | | |
|  | | | | | | | | | | | | | | | | | |
| 3.9 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): | | | | | | | | /    / | | | |
|  |  | | | | | | | | | | | | | | | |
| 3.10 Cover required | Limit of indemnity required: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | £1,000,000 | | | £2,000,000 | | | £5,000,000 | | Other: | | £ | | | | | |

|  |  |  |  |  |  |
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| **Section 4 – Claims** | **You must complete this section. Please complete the claims questions for any risk now to be insured.** | | | | |
| 4.1 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: | | | | |
|  |  | | | | |
|  |  | | | | |
| 4.2 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. | | | | |
|  |  | | | | |
| 4.3 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. | | |  | |
|  |  | | | | |
| 4.4 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 5 –Declaration** | | **You must complete this section.**  **Please read the declaration carefully and sign at the bottom.** | | | | |
| 5.1 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 |
|  |  | | | | | |
|  | |  | | | | |
| 5.2 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. | | | |
|  | |  | | | | |
| 5.3 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.** | | | |
|  | | |  | | | |
| 5.4 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 Relations The Hiscox Building Peasholme Green York 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. | | | | |