

# Medical Malpractice - Medical Establishments

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# Medical Malpractice - Medical Establishments

## PROPOSAL FORM

### A. NOTICE TO THE PROPOSED INSURED

#### 1. Disclosure of Relevant Facts

##### Your Duty of Disclosure

Before you enter into a contract of general insurance with an insurer, you have a duty to disclose to the insurer every matter which you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to us before you renew, extend, vary or reinstate a contract of insurance.

If you do not fulfil this duty, you may receive nothing from the policy.

##### Comment

The requirement of full and frank disclosure of anything which may be material to the risk for which you seek cover (eg. claims, whether founded or unfounded), or to the magnitude of the risk, is of the utmost importance with this type of insurance. It is better to err on the side of caution by disclosing anything which might conceivably influence the insurer's consideration of your proposal.

#### 2. Claims Made Policy

This proposal is for a "claims made" policy of insurance. This means that the policy covers you for claims made against you and notified to the insurer during the period of cover. This policy does not provide cover in relation to:

- events that occurred prior to the retroactive date of the policy (if such a date is specified);
- claims made after the expiry of the period of cover even though the event giving rise to the claim may have occurred during the period of cover;
- claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy;
- claims made, threatened or intimated against you prior to the commencement of the period of cover;
- facts or circumstances of which you first became aware prior to the period of cover, and which you knew or ought reasonably to have known had the potential to give rise to a claim under this policy;
- claims arising out of circumstances noted on the proposal form for the current period of cover or on any previous proposal form.

However, where you give notice in writing to the insurer of any facts that might give rise to a claim against you as soon as reasonably practicable after you become aware of those facts but before the expiry of the period of cover, the policy will, subject to the terms and conditions, cover you notwithstanding that a claim is only made after the expiry of the period of cover.

You should familiarise yourself with our standard form of policy for this type of cover before submitting this proposal.

## IMPORTANT

- Please answer ALL questions fully. If there is insufficient space please provide details on your letterhead.
- Where provided, tick (☐) appropriate box to indicate answer.
- The Applicant will be referred to in this Proposal as "You" or "Your".

## B. DETAILS OF APPLICANT

1. Full name of all entities to be insured (including service, administrative or nominee companies and subsidiaries that you wish to be covered by this policy):

(Hereinafter the applicant will be referred to as "You" or "Your")

.....  
.....

2. Full name of owner.

.....  
.....

3. Principal address of Establishment.

.....  
.....

4. Address(es) of branch offices or other locations.

.....  
.....  
.....

5. How long has the Establishment been operated by the present owners? .....

6. Please supply the following details:

Title of Staff Member	Name	Age	Qualifications	Date Qualified
Chief executive officer	.....	.....	.....	.....
General manager	.....	.....	.....	.....
Director of medical services	.....	.....	.....	.....
Director of allied health services	.....	.....	.....	.....
Director of nursing	.....	.....	.....	.....

7. Is the Establishment duly licensed to practice at the address(es) specified in Question 3 and 4?

YES ☐ NO ☐

8. Please provide total numbers of employees in each of the following classifications:

(a) Surgeons	.....	(f) Pharmacists	.....
(b) Doctors	.....	(g) Registered nurses	.....
(c) Interns	.....	(h) Enrolled nurses	.....
(d) X-ray technicians	.....	(i) Undergraduate of student staff	.....
(e) Laboratory technicians	.....	(j) Other medical or allied health employees	.....
		<b>TOTAL</b>	.....

## C. DETAILS OF ESTABLISHMENT

1. 1.1 Has the name of the Establishment ever been changed? YES ☐ NO ☐
- 1.2 Has any other establishment amalgamated or merged with you? YES ☐ NO ☐
- 1.3 Have you purchased any other establishment? YES ☐ NO ☐

*If you have answered YES to either part C.1.1.1, C.1.1.2 or C.1.1.3, please supply details.*

.....

2. Please list the professional bodies or associations to which the Establishment belongs.

.....

3. Does the Establishment have:

- (a) an intensive care unit? YES ☐ NO ☐
- (b) a casualty or outpatients department? YES ☐ NO ☐
- (c) a radiotherapy unit? YES ☐ NO ☐
- (d) a medical teaching facility? YES ☐ NO ☐

4. Does the Establishment operate any training school? YES ☐ NO ☐

*If YES, please supply details.*

.....

5. Do you maintain accurate descriptive records of all medical services rendered? YES ☐ NO ☐

6. Do you ensure that all doctors of medicine (whether employed or visiting) who provide medical services for, or use the facilities of, the Establishment are members of a recognised medical defence union/association or protection society, or otherwise carry their own malpractice liability insurance covers? YES ☐ NO ☐

7. Is there a blood banking facility? YES ☐ NO ☐

*If YES, please provide the following details.*

- (a) (i) percentage of blood bought ..... %
- (ii) percentage of blood collected ..... %
- (b) (i) approximate number of litres per annum .....
- (ii) approximate number of plasmapheresis procedures carried out per annum .....
- (iii) estimated annual gross receipts from the sale of the following per annum:
- whole blood \$ .....
- blood plasma \$ .....
- serum \$ .....
- other blood products or derivatives \$ .....

- (c) Please provide details of:

- (i) the screening procedure of persons from whom blood or plasma is drawn.
- .....

- (ii) the screening procedure of the products identified in Question 7(b)(iii) prior to their sale, use or disposal.

.....

8. Please provide the approximate division of your patients between:

(a) General medical	..... %	(i) Alcohol & other drugs	..... %
(b) Surgical	..... %	(j) Obstetrics / maternity	..... %
(Please complete questions 12 and 13)			
(c) Oncology	..... %	(k) Neo-natal	..... %
(d) Tubercular / communicable	..... %	(l) Elective cosmetic	..... %
(e) AIDS / HIV	..... %	(m) Elective terminations	..... %
(f) Senile or aged	..... %	(n) Paediatric	..... %
(g) Palliative	..... %	(o) Allied health therapy	..... %
(h) Mental health	..... %	(p) Other (please specify below)	..... %

**Grand total of all divisions above must come to 100%**

9. Please provide (a) the number of beds maintained by the Establishment (including day surgery beds) (a) .....  
(b) the number of bassinets (b) .....

*Please provide figures from the last financial year for questions 10 to 13*

10. Please provide the approximate occupancy rate ..... %

11. Please advise number of (a) Out Patients and (a) .....  
(b) Admitted in Patients, (b) .....

12. Please provide the number of (a) Deliveries (a) .....  
(b) Multiple births (b) .....  
(c) Healthy neonatal (c) .....  
(d) Stillborn infants (d) .....

13. Please provide the number of infants admitted to the NICU / SCBU  
(a) from your own obstetrical department (a) .....  
(b) transferred from entities outside the control of the Establishment (b) .....

14. Do you undertake Clinical Trials? YES ☐ NO ☐  
(if YES, please complete a Clinical Trial Proposal Form if cover is required)

## D. FINANCIAL DETAILS

1. 1.1 Please advise the date of your financial year end: \_\_\_\_/\_\_\_\_/\_\_\_\_

1.2 Please provide the amount of gross income/fees for the following

(a) current financial year (estimate) .....

(b) last financial year .....

(c) previous financial year .....

2. Please provide the approximate percentage of your activities (based on gross income) applicable to each state, territory and overseas.

Country	Singapore	Asia	Europe	USA/Canada	Other
Percentage of income	..... %	..... %	..... %	..... %	..... %

## E. CLAIMS DETAILS

1. Has any Employee of the Establishment ever been subject to disciplinary proceedings for professional misconduct? YES ☐ NO ☐

*If YES, please supply details.*

.....  
 .....

2. Have any claims for malpractice been made in the last ten (10) years against the Establishment or have circumstances been notified to insurers that might give rise to a claim? YES ☐ NO ☐

*If YES, please supply details.*

Date Matter Notified	Name of Insurer (if any)	Name of Claimant or Potential	Brief Description	Amount paid or estimate of Potential Liability	Is Matter Finalised or Outstanding
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....

3. Is the Applicant, AFTER ENQUIRY, aware of any claim or circumstances that might give rise to a claim against the Establishment which matter is not referred to in Question E.2 above? YES ☐ NO ☐

*If YES, please provide the following details in respect to each matter.*

Name of Claimant or Potential Claimant	Brief Description of the Matter	Estimate of Potential Liability
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

## F. DETAILS OF INSURANCE COVER

- 1 Does the Establishment presently carry, or has the Establishment ever carried, malpractice liability insurance? YES ☐ NO ☐

*If YES, please supply details.*

Insurer: .....

Expiry Date: .....

Limit of Indemnity: .....

- 2 Has the Establishment ever been refused this type of insurance, or had similar insurance cancelled, or had an application of renewal declined, or had special terms imposed? YES ☐ NO ☐

*If YES, please supply details*

.....  
 .....

## G. RISK MANAGEMENT

- 1 Do you have and follow documented risk management and quality control procedures YES ☐ NO ☐
- 2 Are these risk management procedures regularly reviewed and updated to the appropriate standards applying to your industry? YES ☐ NO ☐
- 3 Are all appropriate staff members familiar with these procedures and/or standards? YES ☐ NO ☐
- 4 Do you and your staff attend regular continuing education programmes that are organised by your Professional Association or industry bodies or groups? YES ☐ NO ☐

*Please provide a separate written comment to explain why a "No" answer was provided.*

- 5 What procedures do you have for the reporting of medical incidents? Please provide full details.

.....  
.....

## H. APPLICATION FOR COVER

- 1 Limit of indemnity required: .....
- 2 Deductible/Excess requested: ..... (each and every claim)
- 3 Extensions:

### Automatic Extensions

✓ Libel and slander	Automatically Included
✓ Loss of documents	Automatically Included
✓ Coroner's enquiries	Automatically Included
✓ Emergency first aid	Automatically Included
✓ Students	Automatically Included
✓ Newly created or acquired entity or subsidiary	Automatically Included
✓ Run-off cover insured entity or subsidiary	Automatically Included
✓ Estates and legal representatives	Automatically Included

## I. DECLARATION

I am/We the undersigned authorised Insured Person(s), after enquiry declare as follows:

1. I am / We are authorised by each of the other Applicants to make this Proposal.
2. I/We have read and understood the Notice to the Proposed Insured on the front of this Proposal Form.
3. I/We have read this Proposal and the accompanying documents and acknowledge the contents of same to be true and complete.
4. I/We understand that, up until a contract of insurance is entered into, I/We are under a continuing obligation to immediately inform the Insurer of any change in the particulars or statements contained in this Proposal or in the accompanying documents.

It is very important that the signatory of this application form is aware of the nature and scope of the insurance that will be afforded by a policy, if effected, in order to respond accurately to the questions in this application form. If necessary, the signatory of this proposal form should consult their insurance broker or agent, as non-disclosure of material facts may prejudice any rights to be indemnified under a policy, if effected.

Although the signing of this Proposal does not bind the Applicants to effect insurance the Applicants acknowledge that the particulars and statements contained in this Proposal and in the accompanying documents shall be the basis of the contract should a Policy be issued; and further, the Applicants acknowledge that the Proposal and the accompanying documents will be incorporated in the Policy.

Name of Applicant: .....

Signed: .....

Partner, Principal or Director: ..... Date: \_\_\_\_/\_\_\_\_/\_\_\_\_