REGISTERED MEDICAL PRACTITIONERS APPLICATION

PLEASE ANSWER ALL QUESTIONS
IF THEY DO NOT APPLY, INDICATE "N/A" - IF SPACE IS INSUFFICIENT PLEASE USE SEPARATE SHEETS

1. i) Name of Insured: ______________________________

   ii) Date of Birth: ______________________________

2. Trading Name (if different from above): ______________________________

3. Have you ever engaged in a similar activity under a different name? ☐ Yes ☐ No
   If Yes, please give full details:

   ____

   ____

4. i) Address: ______________________________

   ii) Practice/Trading Address (if different from above):

   ____

   If cover is required for more than one location, please attach a list of all addresses.

5. i) At which Medical / Dental school did you qualify? ______________________________

   ii) In what year? ______________ iii) Degree obtained? ______________________________

   Please give details of any additional or post graduate qualifications:

   ____

   ____

6. Please state:

i) The name of your registration or licensing body: ______________________

ii) Your registration number: ______________ iii) Your registration date: ______________

iv) Date of first registration: ______________

v) Are there now or have there ever been any conditions attached to your registration? ☐ Yes ☐ No

vi) Has there ever been any interruption in your registration? ☐ Yes ☐ No

If "Yes" to 6.v) or vi) please provide full details on a separate page.

7. i) In what branch or branches of medicine are you qualified and licensed to practice?

☐ Anesthesiology	☐ Cardiology	☐ Community Medicine
☐ Dermatology	☐ Dentistry*	☐ Endocrinology
☐ General Practice	☐ Genetics	☐ Hematology
☐ Immunology	☐ Industrial Health	☐ Neurology
☐ Nuclear Medicine	☐ Nutrition	☐ Obstetrics/Gynecology*
☐ Ophthalmology*	☐ Orthopedics	☐ Orthodontics
☐ Otorhinolaryngology	☐ Pediatrics	☐ Pathology
☐ Pharmacology	☐ Physiology	☐ Psychiatry
☐ Radiotherapeutics	☐ Rehabilitation	☐ Surgery*
☐ Tropical Medicine	☐ Venereology	

☐ Other (please specify): ______________________

Where marked with an * please complete the relevant sections of the Addenda.

ii) If you are either a G.P. or an Obstetrician/Gynecologist please state the number of:

a) Emergency non-hospital births you attended in the last 12 months: ______________

b) Routine home births you attended in the last 12 months: ______________

iii) If you are a Surgeon please give full details of the type of surgery performed, e.g. Cardiac / Gender Reassignment / Elective Cosmetic / Elective T.O.P. / Organ Transplant / Keyhole / Laser Eye or other Major or Intermediate or Minor Surgery:

____

____

8. i) Are you involved in Clinical Trials for which you require cover? ☐ Yes ☐ No

ii) If Yes, are you under contract with any third party to conduct trials on their behalf? ☐ Yes ☐ No

iii) If Yes, to whom are you under contract: ______________________

iv) Do you receive a full indemnity from your principals? ☐ Yes ☐ No

v) Do all volunteers sign an Informed Consent form? ☐ Yes ☐ No

vi) If Double Blind studies are undertaken are volunteers made fully aware of this? ☐ Yes ☐ No

vii) Do any trials involve female volunteers of child-bearing age? ☐ Yes ☐ No
If Yes, please attach full details.

viii) Please state the number of trials performed during the last 12 months detailing the number of volunteers in each trial:

____

____

ix) Please state the anticipated number of trials with which you will be involved during the next 12 months detailing the number of volunteers in each trial:

____

____

x) Do you conduct any formal research, testing or experimental activities in the following categories? ☐ Yes ☐ No

Transplant	Human Embryo Research	Surgery
Artificial Organ	Genetic Engineering	Obstetrics

If Yes, please attach full details.

PLEASE PROVIDE COPIES OF YOUR INFORMED CONSENT FORM & ANY INDEMNITIES REFERRED TO IN QUESTIONS 8. iv) AND 8. v) ABOVE.

9. Please give full details of what patient records are kept, where and how they are stored and for how long they are retained.

____

____

Please note 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.

10. i) **WHAT IS YOUR TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS?** (If a new business, please state estimated income for the next 12 months)

____

ii) What percentage of your total gross annual income will be earned:

☐ from the U.S.A. ________ % ☐ Other foreign ________ %

11 Do you own (wholly or in part), operate or administer any hospital, nursing home or any other medical establishment? ☐ Yes ☐ No

If the answer is Yes, an additional application form will have to be completed before quotations can be given.

12. Please state the approximate percentage breakdown of your work between the following categories and state whether you are employed or self-employed:

	Employed	Self-Employed
The applicants private practice:		
Public Sector Hospitals / Homes:		
Private Surgical Hospitals / Homes:		
Private Non-Surgical Homes:		
Patients' Homes:		
Other (please specify): ____________		
Total:		

If you are an employee, please state the name of the employing authority or the name of the private hospital or company for which you work.

____

13. Please state the number of staff and give details of the capacity in which they practice:

____

____

14. i) 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 place patients / clients at risk? ☐ Yes ☐ No

If Yes, what procedures are in place:

____

ii) Has the applicant or any employee involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries? ☐ Yes ☐ No
If Yes, please give full details:

____

____

15. i) Are you a member of any professional organization, or registered with any self regulating body? ☐ Yes ☐ No
If Yes, please state which and period of membership / registration:

____

ii) Has membership of / registration with such organization / body ever been suspended, withdrawn, amended or declined or had conditions attached? ☐ Yes ☐ No
If Yes, please give full details:

____

16. If you are any employee, is it a condition of your employment that you maintain Medical Professional Liability Insurance? ☐ Yes ☐ No
If Yes, please give full details:

____

17. Have you ever been Insured for Medical Professional Liability? ☐ Yes ☐ No

i) If Yes, please indicate the name of the Insurer:

____

ii) Please indicate if such coverage is offered on an occurrence basis or claims made basis.

☐ Occurrence ☐ Claims Made

iii) If current coverage is on a claims made basis, what is the retroactive date? ____________________

iv) What is your current policy limit? ____________________

v) What is your current deductible? ____________________

vi) If you are presently insured, are renewal terms being offered? ☐ Yes ☐ No
If No, please state reason:

____

____

18. To your knowledge, has any company declined or terminated the insurance for you, any present partner or officer or for any predecessor in the business, past partners or officers? ☐ Yes ☐ No

If Yes, please provide details:

____

____

19. a) Have any claims ever been made to your knowledge against you, any business predecessors, or any of the present or former partners or officers? ☐ Yes ☐ No

b) Are you aware of any act, error, omission or circumstances which could give rise to a claim against you or any predecessor in business, or any present or former partner or officer? ☐ Yes ☐ No

IF THE ANSWER TO EITHER Q.19 a) OR Q.19 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 19. a) AND/OR 19. b) OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

20. Insurance required:

LIMITS:			**DEDUCTIBLES:**		
	$1,000,000	☐		$ 1,000	☐
	$2,000,000	☐		$ 2,500	☐
	$3,000,000	☐		$5,000	☐
	$4,000,000	☐		$10,000	☐
	$5,000,000	☐		$25,000	☐
Other:	____________	☐	Other:	________	☐

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed or misstated any material facts and I/we agree that this declaration shall be the basis of any binder or contract or insurance with the Insurer, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurer to the issue of the insurance nor the Applicant to the purchase of the insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 19. a) or 19. b) of this application, the Insurer shall be immediately notified in writing of such information.

THE UNDERSIGNED HEREBY ACKNOWLEDGES THE TRUTH OF THE STATEMENTS CONTAINED HEREIN.

I AUTHORIZE YOU TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION AS PERMITTED BY LAW, IN CONNECTION WITH YOUR COMMERCIAL INSURANCE POLICY OR A RENEWAL, EXTENSION OR VARIATION THEREOF, FOR THE PURPOSES NECESSARY TO ASSESS THE RISK, INVESTIGATE AND SETTLE CLAIMS, AND DETECT AND PREVENT FRAUD, SUCH AS CREDIT INFORMATION, AND CLAIMS HISTORY.

For purposes of the Insurance Companies Act (Canada), this document was issued in the course of Lloyd's Underwriters' insurance business in Canada.

Signature of Applicant (authorized representative) ______________________

Date ______________________

SUBMITTED BY: ______________________

EMAIL: ______________________

For contact information visit:
www.markelinternational.ca

ADDENDUM 1 - DENTISTRY

1. Are general anaesthetics ever administered? ☐ Yes ☐ No
   If No, please proceed to question 10.

2. Do you personally administer general anaesthetics? ☐ Yes ☐ No
   If No, please ignore questions 3. And 4.

3. Do you have appropriate post-graduate training and relevant experience in the use of anesthetic drugs for dental purposes? ☐ Yes ☐ No
   If Yes, please provide details:

   ____

4. Does a Dentist other than yourself treat the patient? ☐ Yes ☐ No

5. If the answer to 2 is No, is the anesthetic administered by a dental or medical practitioner with appropriate post-graduate training and relevant experience in the use of anesthetic drugs for dental purposes? ☐ Yes ☐ No

6. Does the person administering the anesthetic (the "Anesthetist") always remain with the patient throughout the anesthetic procedure and until the patient's protective reflexes have returned and the patient has recovered control of his / her airway? ☐ Yes ☐ No

7. How many assistants are present throughout the procedure? ______________

8. Does the Anesthetist always have an assistant in support throughout the procedure and recovery? ☐ Yes ☐ No

9. Is the person providing the dental treatment always assisted by a dental surgery assistant / dental nurse? ☐ Yes ☐ No

10. Is sedation ever administered? ☐ Yes ☐ No
    If No, please proceed to question 12.
    If Yes:

    i) Is this personally administered by you? ☐ Yes ☐ No

       If "No" please indicate the type of practitioner who administers the sedation (e.g. Dentist or Anesthetist):

       ____

    ii) What type of sedation is administered?

       ☐ Intravenous ☐ Inhalation ☐ RA

    iii) If you have indicated intravenous sedation, does the practitioner administering the sedation have post-graduate training in this procedure? ☐ Yes ☐ No

11. Is a dental surgery assistant / dental nurse present throughout the procedure? ☐ Yes ☐ No

    If Yes, does he / she have training and experience in assisting in procedures of sedation, including monitoring the clinical condition of the patient and assisting in an emergency? ☐ Yes ☐ No

12. Is the operating room equipped with continuously-acting monitoring devices and a defibrillator? ☐ Yes ☐ No

13. Is there basic life support equipment set up ready for use in the operating room? ☐ Yes ☐ No

14. Are patients ever left unattended while under general anesthesia or sedation or in recovery? ☐ Yes ☐ No

15. Is a full medical history of the patient always taken prior to administration of general anesthesia or sedation? ☐ Yes ☐ No

16. Are patients always given written pre- and post-treatment instructions in advance of the procedure? ☐ Yes ☐ No

ADDENDUM 2 – OBSTETRICS / GYNACOLOGY / SURGEONS

1. Please state the number of Deliveries per annum ____________

   Including:
   - Multiple Births ____________
   - Healthy Neonatals ____________
   - Stillborn Infants ____________
   - Infants delivered at less than 32 weeks ____________
   - Infants delivered at less than 1501 grams ____________
   - Infants with an Apgar rate of less than 6 at 5 minutes ____________
   - Number of infants admitted to the NICU/SCBU ____________

2. Is an Anesthetist available solely to the obstetrical department 24 hours a day? ☐ Yes ☐ No

3. Is a second Anesthetist on call 24 hours per day who is able to attend within 30 minutes? ☐ Yes ☐ No

4. Are facilities available to you for emergency Caesarean sections to be performed 24 hours per day? ☐ Yes ☐ No

5. Is a second Obstetrician on call 24 hours a day who is able to attend within 30 minutes? ☐ Yes ☐ No

6. Is a Pediatrician available "in-hours" 24 hours per day? ☐ Yes ☐ No

ADDENDUM 3 – OPTHALMOLOGY

1. Do you perform laser eye surgery? ☐ Yes ☐ No
   If Yes, provide full details on a separate page.

CLAIMS HISTORY

Applicants Name: ______________________ Date: __________

Claimant: ______________________

Date of Loss: ______________________ Suit: ☐ Yes ☐ No

Amount Claimed: ______________________ Estimated Liability: __________

Indemnity Paid: ______________________ Expenses Paid: __________

Closed: Yes ☐ No ☐

Description of Claim: ______________________

Applicants Name: ______________________ Date: __________

Claimant: ______________________

Date of Loss: ______________________ Suit: ☐ Yes ☐ No

Amount Claimed: ______________________ Estimated Liability: __________

Indemnity Paid: ______________________ Expenses Paid: __________

Closed: Yes ☐ No ☐

Description of Claim: ______________________

Applicants Name: ______________________ Date: __________

Claimant: ______________________

Date of Loss: ______________________ Suit: ☐ Yes ☐ No

Amount Claimed: ______________________ Estimated Liability: __________

Indemnity Paid: ______________________ Expenses Paid: __________

Closed: Yes ☐ No ☐

Description of Claim: ______________________