

Introduction

The purpose of this application form is for us to find out more about you. Completion of this application form does not oblige either you or us to enter into a contract of insurance. Following a reasonable search you must provide us with all information which may be material to the cover we offer in a clear and accessible manner. Information is material if it would influence our decision whether to insure you, what cover we offer you or what premium we charge you. If you are in any doubt whether a fact or circumstance is material you should disclose it

How to complete this form

This form should be completed by the applicant who should make all the necessary enquiries to enable our questions to be answered. If you require extra space to answer the questions or provide any other material information, please use the additional information section at the back of the form. Once you have completed the form please return it directly to your insurance broker

Section 1: Personal Details

1.1 Please provide the following details:

Title:

Full Name:

Previous surname (if applicable):

Gender:

Date of birth (DD/MM/YYYY):

Personal Address:

Postcode:

Practice Address:

Postcode:

Mobile Telephone number:

Practice telephone number:

E-Mail:

Section 2: Qualifications

2.1 Please state:

a) your primary medical qualification and the name of the university and the country where you studied:

Primary medical qualification:

Name of the university:

Country:

b) the year in which you achieved your primary medical qualification:

c) what post graduate qualifications you have attained or any areas of specialist training or fellowships:

d) your GMC Registration Number:

e) the date of original GMC Registration:

f) whether you are on any specialist register or the GP register:

Yes No

If "yes", please state which one(s) and the entry date(s):

Register Entry Date

g) whether you are a member of any professional association(s):

Yes No

If "yes", please provide full details:

Section 3: NHS Practice

3.1 Please state whether you are currently practising as an:

a) NHS GP Yes No

b) NHS Hospital GP Yes No

c) NHS Consultant Yes No

If you answered "yes" to any of a) to c) above, please state whether you have been continually practising in the UK for the past two years:

Yes No

3.2 Please state whether you plan to retire or cease practice in the UK during the next 5 years:

Yes No

If "yes", please provide the anticipated dates below and provide further details on the Additional Information Page:

from the NHS: from Private Practice: from Medical Legal Work:

3.3 If you have answered "yes" to 3.2 above, please state whether you intend to undertake any voluntary work after you retire:

Yes No

If "yes" please provide full details:

3.4 Please state whether you undertake any Category 2 Medico Legal work for which you require cover:

Yes No

a) If "yes", please state the gross annual income you generate from this activity: £

3.5 Please state if you require cover for any private activities which are not covered by the NHS:

Yes No

If "yes", please complete the Private Doctors Activities Supplementary Questionnaire.

Section 4: Cyber Security

4.1 Please state whether you are registered as a data controller under the Data Protection Act: Yes No

If you hold personally identifiable data on your own electronic system you must be registered with the Information Commissioners Office.

If you hold electronic data on your patients, please state whether you:

a) have anti virus software installed and enabled on all of your IT equipment, including desktops, laptops and servers (excluding database servers) and confirm that it is updated on a regular basis: Yes No

b) have firewalls installed on all external gateways: Yes No

c) take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or whether you outsourced service provider meets this requirement: Yes No

Section 5: Claims Experience

5.1 Please answer the following questions in relations to the NHS, Private Practice and any overseas work. Please consider all relevant information and if in doubt, refer to your broker. Regarding all of the types of insurance to which this application form relates.

After full enquiry:

a) have you ever been or are you currently subject to any:

i. form of disciplinary action or investigation by a regulator, employer, private hospital or clinic where you hold or have held practicing privileges? Yes No

ii. claim, **complaint*** or allegation of negligence (even if the outcome was in your favour)? Yes No

iii. conditions or suspension to practice by any employer, private hospital or clinic where you hold or have held practicing privileges? Yes No

iv. adverse findings, conditions, suspension or erasure by a regulator, registration body or equivalent? Yes No

b) have you ever had your practicing privileges suspended, reviewed or revoked? Yes No

c) are you aware of any incidents or circumstances which may lead to:

i. any claim, **complaint*** or allegation of negligence? Yes No

ii. disciplinary action or suspension from practice? Yes No

iii. conditions or restriction on your practice? Yes No

iv. removal of your name from a Professional or Regulatory Register or suspension of practicing privileges? Yes No

v. any investigation by a regulator, registration body or equivalent? Yes No

d) have you ever been subject to a Medical Defence Organisation Adverse Member Procedure? Yes No

e) have you ever had your membership of a Medical Defence Organisation or similar refused, cancelled or non-renewed? Yes No

f) has any insurer ever declined to insured you, imposed special terms, cancelled or declined to renew your insurance? Yes No

g) have you ever been convicted of any criminal offence or received a formal caution not spent under the Rehabilitation of Offenders Act 1974? Yes No

**Please note that "complaint" includes but is not limited to any verbal or written complaint or any expression of dissatisfaction.*

If the answer to any of the above is 'yes' then please attach full details including an explanation of the background of events, all relevant dates, the status of the claims or circumstances, the maximum amount involved or claimed and any reserves or payments made.

Any matters disclosed in this application, including any application previously submitted to us, will not be covered unless otherwise specifically covered by endorsement.

Section 6: Insurance Coverage

6.1 Please advise the first day that coverage is required (DD/MM/YYYY):

6.2 Please fill in the below regarding your current and historical provider(s) of medical liability protection

Name of Provider (e.g. MDU/MPS/ MDDUS or Insurer):	Start Date:	End Date:	Cover Limit (if insurer):
			£
			£
			£
			£

6.3 Please state whether you have previously had cover on a "claims made" basis? Yes No

If "yes", please state the retroactive date (DD/MM/YYYY):

6.4 Please state whether any proposal for similar insurance made on behalf of the proposer's business, any predecessor to the business, or any Partner, Principal or director has ever been declined, cancelled, been refused renewal or had special terms imposed (other than general market increases)? Yes No

If "yes", please provide full details:

6.5 Please state how much you currently pay for your medical indemnity: £

Section 7: Declaration

I declare that:

- After full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;
- I will inform underwriters before cover incepts of any change to the information supplied by me; and
- I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Signed:

Full Name:

Date (DD/MM/YYYY):

Data Protection Act – All personal information supplied by you will be treated in confidence by CFC Underwriting Ltd and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of CFC Underwriting Ltd or our agents or subcontractors.



Doctors and NHS Practitioners

Insurance application form



Additional Information