

# INDIVIDUAL COVER

## MEDICAL INDEMNITY REGISTER

GROUP INSURANCE DIVISION

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LONDON SW19 8WA



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### PROPOSAL FORM

#### **MEDICAL MALPRACTICE (AND PUBLIC LIABILITY)** **NON-SAMARITAN ACT INSURANCE FOR INDIVIDUALS, VOLUNTEERS AND FIRST AID TRAINERS ETC.**

PLEASE PRINT AND ANSWER ALL QUESTIONS

01/05/2007

<b>1. Name of individual to be insured:</b>	
How long has the proposer been qualified?	

<b>2. Principle address</b>	
Town	Post code
County	Country
If other locations to be protected please list them hereunder or write 'none'	

<b>3. Please give a brief resume of your medically related skills</b> (continue on a separate sheet if necessary)

<b>4. Average number of emergency calls per year?</b>	
Average number of 'routine' trips per year?	
Radius of operation?	

<b>5. Details of first aid services provided (eg., sports or social events etc)</b>	
Type of events	
Average number per year?	
Number of crew members per event? (if applicable)	
Approximate fee/income derived from this work?	£

<b>6. Details of first aid training provided</b>	
Type of courses?	
Average number per year?	
Are FAW courses registered with the HSE?	
Maximum students per lecturer?	
Number of instructors/examiners per course? *	
Approximate fee/income derived from this work?	£

\* As you are applying as an individual please bear in mind that other instructors/examiners will not be covered under your insurance. If they require cover they will need to take it out as individuals as well. (See web site [www/medicalindemnity.com](http://www/medicalindemnity.com) for more forms)

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<b>7. Is an air ambulance repatriation service maintained?</b>	<b>Yes or No?</b>	
If yes, please state -		
All territories in which you expect to operate		
Number of repatriations per year		
Type of repatriation service available		
Approximate fee/income derived from this type of work?	£	

<b>8. Please state your total fee/income/donations or receipts – (Must be answered)</b>		
For the past twelve months?	£	
Estimated for the next twelve months?	£	

<b>9. Who, if any, are your present insurers?</b>		
Name of insurer?		
Present policy limits of indemnity?		
What is deductible?		
Expiry date of present policy?		

<b>10. Have any claims or suits alleging negligence, error or omission been made against yourself or are there any circumstances of which you may be aware, which may give rise to a claim?</b>		
		Please answer 'yes' or 'no'
<input type="checkbox"/>		
If the answer is yes, please give full details below and, if necessary, on a separate sheet.		

<b>11. Has any insurer ever cancelled, declined, refused to renew, or only accepted on special terms your insurance?</b>	
<b>(Please answer 'yes' or 'no')</b>	
If the answer is yes, please give full details below and, if necessary, on a separate sheet.	

<b>12a. Amount of Medical Malpractice insurance required?</b>		
<b>12b. Do you require Public Liability insurance? (Please tick as appropriate)</b>	YES?	NO?

<b>14. Preferred effective date of cover (if known):</b>	
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I hereby declare and warrant that the above statements and particulars are in all respects complete and true, that they are material and I have not suppressed or mis-stated any material facts and I agree that this proposal form shall be the basis of the contract with underwriters and deemed part of the insurance coverage issued to me.	
Signature of proposer:	Date:
Name in full (please print):	
Qualification:	E-mail:
Contact telephone number:	Fax:

This proposal form, duly completed, together with any supplementary information must be signed in ink by the proposer. One signed copy will be attached to the Policy or Certificate if issued. Signing of this form does not bind the Proposer or the Underwriter to complete the insurance.

**Please attach any other information concerning yourself or organisation that may be of relevance to underwriters when assessing your proposal.**

WHEN COMPLETED THIS FORM SHOULD BE RETURNED TO THE MEDICAL INDEMNITY REGISTER WHO WILL IN TURN SUBMIT IT TO UNDERWRITERS FOR CONSIDERATION.
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