Medical Malpractice Insurance Policy

Proposal Form

ADNIC is a Public Joint Stock Company incorporated in the United Arab Emirates by Law No. (4) of 1972, and it is governed by the provisions of the UAE Federal Law No. (6) of 2007 "Establishment of the Insurance Authority & Organization of its Operations", with Registration No. (1).

Completing this form

In order to apply for this insurance, please complete all parts of this proposal form and the annexures, if any.

You must provide full, accurate, and true answers to all questions listed below. Material facts which you know or ought to know should be fully and accurately disclosed. Failure to do so may result in rejecting your claim and/or terminating the insurance policy from inception.

If you are in any doubt about what you should disclose, please do not hesitate to contact us. A material fact is one that would influence our decision whether to offer you insurance or the terms which we offer.

If the space provided is inadequate, please provide details using an additional information sheet, signed and dated.

Your insurance does not commence when you sign the proposal. Your cover will only commence once we have reviewed the proposal form and confirmed cover in writing.

Please keep a copy of this proposal form for your record along with any correspondence/ information provided to us and policies/endorsements that are issued to you subsequently.

1. General information

a. Full name of institution (hereinafter referred to as "the proposer")

_____

_____

b. i) Registered address (Please show the address required on the policy)

Contact person's name: _____

P.O. Box: _____ City: _____

Country: _____ Mobile number: _____

Phone number: _____ Email address: _____

Fax number: _____ Website address: _____

ii) Trading address

Contact person's name: _____

P.O. Box: _____ City: _____

Country: _____ Mobile number: _____

Phone number: _____ Email address: _____

Fax number: _____ Website address: _____

c. VAT Tax Registration Number (if applicable): _____

Note: For additional locations, please provide a separate sheet

d. Date when the company was established: _____

e. Please name the ultimate owner or holding company: _____

f. Is the proposer

i) Approved and registered by a public authority? ☐ Yes ☐ No

Name of the authority and date of approval: _____

ii) A member of a hospital association? ☐ Yes ☐ No

Name of the association and date of acceptance: _____

iii) Has membership or registration with such ever been suspended, withdrawn, amended or declined, or had conditions attached? ☐ Yes ☐ No

g. Is the proposer maintained in whole or in part by public or private funds or endowment? ☐ Yes ☐ No

If Yes, please specify: _____

_____

_____

2. Nature and volume of your present and foreseeable future activities

a. Brief description of the proposer's activities (e.g. operations of a hospital, nursing home)

i) Hospital	☐ Yes	☐ No
ii) Acute Care hospital	☐ Yes	☐ No
iii) Specialty hospital (Specialty to be declared)	☐ Yes	☐ No
iv) Psychiatric hospital	☐ Yes	☐ No
v) Nursing homes	☐ Yes	☐ No
vi) Ambulatory Surgery centers	☐ Yes	☐ No
vii) Rehabilitation centers	☐ Yes	☐ No
viii) Clinic/Polyclinic	☐ Yes	☐ No
ix) Individual Laboratory services	☐ Yes	☐ No
x) Individual Pharmacies	☐ Yes	☐ No
xi) Individual Ambulance services	☐ Yes	☐ No

b. Gross annual income

Last financial year: AED _____

Current financial year: AED _____

Next financial year (estimate): AED _____

c. Number of patients per year

Department	Out-patients	In-patients	Total
General			
Surgical			
Gynecological and obstetrical			
Pediatric			
Orthopedic			
Dental			
Psychiatric			
Others, if any			

2. Nature and volume of your present and foreseeable future activities (continued)

d. Number of beds available and their daily occupancy

Beds	Numbers	Average daily occupancy
Bassinet		
Neonatal ICU		
Obstetric		
Pediatric		
Psychiatric		
Others, if any		

e. Number of employed doctors (including doctors in clinics) in each of the following classifications:

i) Physicians

- General: _____
- Psychiatrist: _____
- Others: _____

ii) Surgeons

- Orthopedic: _____
- Neurosurgeons: _____
- Cosmetic/Plastic Surgeons: _____
- Eye Surgeons: _____
- Dental Surgeons: _____
- Anesthetists: _____
- Gynecologists: _____
- Internal specialists: _____
- Urologists: _____
- Orthopedists: _____
- Radiologists: _____
- Ophthalmologists: _____
- Dentists: _____
- Oncologists: _____
- Others, if any (please specify): _____

_____

_____

2. Nature and volume of your present and foreseeable future activities (continued)

f. Number of Allied Health Care Professionals

i) Nurse Category

- Nurse Practitioners: _____
- Certified Nurse Midwife: _____
- Certified Registered Nurse Anesthetist/Anesthesiology assistant: _____
- Registered Nurse/Nurse Managers: _____
- Licenced Practical Nurses: _____

ii) Assistant/Technician Category

- Physician Assistant: _____
- Ophthalmologist: _____
- Pharmacist: _____
- Laboratory Assistant: _____

g. Do you require that all professionally qualified medical staff:

i) Be registered with or licensed by the relevant government regulatory body or licensing and registration body? ☐ Yes ☐ No

ii) Be adequately trained and competent for their role? ☐ Yes ☐ No

iii) Be adequately supervised under the appropriate management? ☐ Yes ☐ No

iv) Be recredentialed on on annual basis? ☐ Yes ☐ No

If No, how often are medical staff members recredentialed?

_____

_____

3. Additional facilities

a. Radiology

i) Does the proposer own or operate X-ray machines, lasers, ultrasound machines, or similar equipment?

☐ Yes ☐ No

If Yes, please specify and give number of machines, type and whether they are used for diagnosis or treatment or both: _____

_____

3. Additional facilities (continued)

ii) Does the proposer use radioactive materials? ☐ Yes ☐ No

If Yes, please specify machinery and/or materials used: _____

_____

b. Blood Bank

i) Does the proposer operate a blood bank? ☐ Yes ☐ No

If Yes, please advise percentage of use

- For own purpose: _____ %
- For supply to other parties: _____ %

ii) Is any blood or blood product bought or obtained from outside the country in which you operate ☐ Yes ☐ No

If Yes, please specify where the products are obtained: _____

_____

iii) Are all blood or blood product units tested before use? ☐ Yes ☐ No

iv) Do you outsource any of your blood tests? ☐ Yes ☐ No

If Yes, do the outsourcing companies each carry suitable professional liability insurance? ☐ Yes ☐ No

If Yes, what is the policy limit? _____

_____

c. Ambulances

i) Are ambulances used as ☐ First Responders ☐ Patient Transport ☐ Both

ii) Do ambulances transport perinatal, neonatal or pediatric patients? ☐ Yes ☐ No

iii) Number of ambulances owned or operated: _____

iv) Number of air ambulance owned or operated: _____

v) Number of emergency movements within the last 12 months: _____

vi) Number of non-emergency movements within the last 12 months: _____

vii) Please list the countries in which you operate ambulance services: _____

_____

_____

3. Additional facilities (continued)

d. Emergency services

i) Do you provide 24/7 attending emergency medicine physician/registrar cover? ☐ Yes ☐ No

ii) Please specify your average wait time (in times): _____

iii) Do any of the emergency department staff routinely work more than a 12-hour shift? ☐ Yes ☐ No

e. Pharmacy

i) Do you provide pharmacy services to other organisations? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

ii) Do you have written procedures for pharmacy safety control/risk management? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

iii) Do you utilize electronic bar-coding in medication management? ☐ Yes ☐ No

iv) Please confirm if a pharmacist is available 24/7? ☐ Yes ☐ No

v) Are you in compliance with all applicable regulatory laws governing the manufacture, control dispensing, and distribution of prescription drugs? ☐ Yes ☐ No

f. Telemedicine

i) Do you provide Primary (doctor to patient) or Secondary (doctor to doctor review) Telemedicine?

☐ Primary ☐ Secondary ☐ Both

ii) In what countries do you practice telemedicine? _____

iii) How many telemedicine encounters do you average per year? _____

iv) Do all providers use standardized clinical protocols when conducting Telemedical interviews? ☐ Yes ☐ No

g) Do you request indemnity from any institutions to whom you provide Secondary Telemedicine services? ☐ Yes ☐ No

Please use this space to record any additional information in relation to the above services:

_____

_____

_____

4. Risk Management & Quality Assurance

a. Staff member responsible for risk management

Name: _____ Position: _____

b. Do you have a documented risk management programme? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

c. Do you provide facilities for the sterilisation of instruments in accordance with current guidelines and do you ensure that cross infection control methods are employed? ☐ Yes ☐ No

d. Do you comply with the current guidelines for the safe collection and disposal of any clinical/medical waste products? ☐ Yes ☐ No

e. Are your medical records ☐ Written ☐ Electronic

f. How long are medical records retained from the date of treatment? _____

g. Is informed consent obtained from each patient and documented in the medical record?

If No, how often is informed consent obtained? _____

_____

h. What measures are in place for the protection of sensitive information and compliance with relevant privacy legislation? _____

_____

i. Do you have a formal programme for clinical quality assurance? ☐ Yes ☐ No

If Yes, please attach details: _____

_____

j. Please comment below on how clinical quality is maintained in line with best practice within your industry and how this is benchmarked against your peers: _____

_____

5. Complaints management

a. Do you have a written procedure for the reporting of incidents and adverse events? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

5. Complaints management (continued)

b. Do you have a written procedure for the investigation of adverse events? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

If No to either of the above (a & b), please provide a commentary on how incidents and adverse events are reported and investigated: _____

_____

_____

c. Do you have a complaints manager and a written procedure for the handling of patient complaints?

☐ Yes ☐ No

If Yes, please provide details: _____

_____

If No, please provide details on how patient complaints are handled in your organization:

_____

_____

d. Do you currently manage claims in-house? ☐ Yes ☐ No

If Yes, please attach details of your approach to claims reserving: _____

_____

e. During the last 10 years has any claim been made, defended or settled, or has any malpractice or negligence been alleged against you? ☐ Yes ☐ No

f. Are there any circumstances which may result in a claim against you or any prior corporate practice, predecessors in business or any present or former partner, principal, director, or professional practitioner? ☐ Yes ☐ No

g. Has any partner, principal, director, or member of staff ever been subject to disciplinary proceedings for professional misconduct? ☐ Yes ☐ No

If you have answered Yes to any of the above, please list all circumstances/claims over the last 10 years in a separate sheet.

h. Please provide details of any third party administrator, loss adjustor or legal firm who you currently use in the handling of your claims: _____

_____

_____

6. Previous insurance and claims particulars

a. Has the proposer previously been insured? ☐ Yes ☐ No

If Yes, please specify: _____

Name of insurer	Policy period	Limit of indemnity
1.		
2.		
3.		
4.		
5.		

b. Has prior cover been on a claims made basis? ☐ Yes ☐ No

If Yes, what is the current retroactive date? _____

c. Has a previous application been declined? ☐ Yes ☐ No

i) Has a previous insurance

- Required increased premium? ☐ Yes ☐ No
- Required special restrictions? ☐ Yes ☐ No
- Been terminated/not been renewed by an insurer? ☐ Yes ☐ No

If you have answered Yes to any of the above, please provide with detailed information:

_____

_____

_____

_____

7. Coverage requirement

a. Limit any one claim (in AED): _____

b. Limit in the annual aggregate (in AED): _____

c. Deductible each and every claim to be borne by insured (in AED): _____

d. Retroactive period: _____ (dd/mm/yyyy)

e. Period of insurance: From: _____ (dd/mm/yyyy) To: _____ (dd/mm/yyyy)

f. List of medical staff to be covered (please provide by separate attachment including their specialization)

g. Please provide details of the territories/legal jurisdiction(s) in which coverage is required:

_____

_____

_____

8. Extensions required

a. Visiting doctors extension: ☐ Yes ☐ No

If Yes, give the following particulars:

Inward (Medical staff visiting your facility)

Speciality	Number of physicians	No. of visits per doctor any one year	Name and address/location of such medical staff

Do you insist the above staff to

i) Carry their own medical professional liability insurance? ☐ Yes ☐ No

If Yes, please specify the limits required: _____

_____

ii) Provide evidence of this coverage on an annual basis? ☐ Yes ☐ No

8. Extensions required (continued)

Outward (Your medical staff visiting other facilities)

Speciality	Number of physicians	No. of visits per doctor to each hospital/clinic any one year	Name and address/location of the hospitals/clinics

b. Public liability extension ☐ Yes ☐ No

If Yes, please specify the limits of indemnity required:

i) Limit any one claim (in AED): _____

ii) Limit in the annual aggregate (in AED): _____

iii) Deductible each and every claim to be borne by insured (in AED): _____

9. Additional information

Please outline any further information that you believe may affect the underwriter's consideration of the risk.

_____

_____

_____

_____

_____

Declaration

I/We hereby declare that the statements/information given by me/us in the Proposal Form are full, accurate and true. It is hereby understood and agreed that the statements, answers and particulars provided in this Proposal Form and as per the attachments are the basis on which the insurance policy is being issued/effected. If after the insurance policy is effected, it is found that any fact in the statements, answers or particulars in this Proposal Form is incorrect, untrue, inaccurate, misrepresented or non-disclosed in any material respect, ADNIC shall have no liability under the insurance policy and/or shall have the right to terminate the insurance policy from inception.

Name of Proposer: _____

Title: _____

Signature: _____

Stamp: _____

Date: _____

Note: Please note that each page of the proposal form should be signed by the Proposer or its legal representative