ELYSIUM INSURE

INTERNATIONAL HEALTHCARE PROVIDERS PROPOSAL FORM

This Proposal Form and all materials submitted will be held in confidence.

All questions must be fully answered and all requested information and/or required attachments must be submitted to enable a quotation or premium indication to be given. The completion and submission of this form does not bind the Proposer or Underwriters to enter into any contract of insurance.

If a question does not apply, please indicate with N/A. If the answer is none, please state "none" or "0". If more space is required, then please utilise the supplementary pages at the back of this form, which must be signed and dated by the authorised officer of principal of the business.

Currencies must be provided for any financial information given.

Insurance is a contract of utmost good faith, this means that the information you provide in this Proposal Form must be complete, accurate and not misleading. In accordance with Section 3 of the Insurance Act 2015 it is your duty to make a fair representation of the risk and to disclose to Underwriters all circumstances and representations material to the proposed insurance.

A circumstance or representation is deemed material if it would influence the judgement of insurers in determining whether to take the risk and on what terms.

This Proposal Form is for a "claims-made" policy. A "claims-made" policy only responds to claims made against the Insured and notified to Insurers during the period of insurance arising from treatment provided on or after the policy commencement date (or retroactive date where applicable).

GENERAL INFORMATION

Name of Organisation	Trading Name (*if different from Organisation Name*)
Principal Trading Address	**Registered Address (*if different from Trading Address*)**
Website Address	**Date Established**
Telephone Number	**Contact Email Address**

BUSINESS INFORMATION

- ☐ For-Profit
- ☐ Not-For-Profit
- ☐ Governmental Entity
- ☐ Sole Trader
- ☐ Partnership
- ☐ Franchise
- ☐ Corporation
- ☐ Professional Association

If other, please provide details: _____

Gross Fee Income/Revenue/Turnover/Gross Receipts for the past financial year:
Gross Fee Income/Revenue/Turnover/Gross Receipts for the current financial year:

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Please give a full description of your business activities for which cover is required:

Where does the proposer provide services for the client? (must equal 100%)

Proposer's Location	%	Mobile Facility	%	Patient's Home	%
School	%	Care Home Facility	%	Hospital	%

If other, please provide details: _____

_____

From the list below, does the proposer intend to make any substantial changes in activity or are any major or new developments likely to occur within the next 12 months? *(If yes please provide details on a supplementary sheet)*

i. Obtain another operation or entity	☐ Yes	☐ No
ii. Increase the number of employees	☐ Yes	☐ No
iii. Expand the number of locations	☐ Yes	☐ No
iv. Eliminate/Add current services	☐ Yes	☐ No
v. Operate on other countries	☐ Yes	☐ No

Has the proposer acquired, sold or discontinued any operations in the past 5 years? *(If yes please provide details on a supplementary sheet)*

☐ Yes ☐ No

Please provide the names and descriptions of all legal entities that the proposer intends to cover as Additional Insured's.

Insured Name	Nature of Services	% of Ownership	Acquisition Date	Retroactive Date	% of Financial Interest

EXPOSURE INFORMATION

Number of licensed beds

Inpatient Beds	2022 (estimate)	2021	2020	2019	2021 average occupancy
Acute Care					
Paediatric					
Bassinet					
ICU					
NICU					
Obstetric					
Alcohol/Drug					
Psychiatric					
Rehabilitation					
Skilled Nursing					
Long Term Care					

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Number of procedures/patient visits

	Number of Procedures/Patient Visits						
Types of procedures/ patient visits	2022 (estimate)	2021	2020	2019	Average length of stay	% of patients under 18	% of patients from the USA
Inpatient Surgery							
Outpatient Surgery							
Outpatient Visits							
Lab & Pathology							
Accident & Emergency							
Home Health Visits							

Obstetrics/Gynaecology

	Total number of births	% of Vaginal births	% of C-Sections	% of VBAC births
Last Year (actual)				
Next Year (estimate)				

i. Is this a referral centre for high risk births, mothers or infants? ☐ Yes ☐ No

ii. Is an obstetrician available on site 24/7 ☐ Yes ☐ No

iii. Is there an obstetrician on call 24/7 who can attend within 30 minutes? ☐ Yes ☐ No

iv. Is there a neonatologist available on site 24/7? ☐ Yes ☐ No

v. Is there a neonatologist on call 24/7 who can attend within 30 minutes? ☐ Yes ☐ No

Medical Practitioners

Doctors and Surgeons /Specialty	Employed		Non- Employed	
Cover Required	Yes	No	Yes	No
Abdominal				
Anaesthesiology				
Bariatric				
Cardiac				
Colon and Rectal				
Colonoscopy				
Cosmetic Surgery				
Cytopathology				
Dentistry				
Dermatology				
Diabetes				
Endocrinology				
Family Physicians				
Gastroenterology				
General Practice				
Geriatrics				
Gynaecology				
Haematology				

Doctors and Surgeons /Specialty	Employed		Non- Employed	
Cover Required	Yes	No	Yes	No
Neurology				
Nuclear Medicine				
Obstetrics				
Occupational Medicine				
Oncology				
Ophthalmology				
Optometrists				
Oral/Maxillofacial				
Orthopaedic				
Otology				
Otorhinolaryngology				
Paediatric				
Pathology				
Perinatology				
Psychiatry				
Plastic Surgery				
Podiatrist				
Psychiatry				

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Medical Practitioners Continued

Doctors and Surgeons /Specialty	Employed		Non- Employed	
Cover Required	Yes	No	Yes	No
Hand				
Head and Neck				
Infectious Disease				
Intensive Care				
Laryngology				
Legal/Forensic				
Lymphangiography				
Neonatology				
Nephrology				

Doctors and Surgeons /Specialty	Employed		Non- Employed	
Cover Required	Yes	No	Yes	No
Psychology				
Radiology				
Sports Medicine				
Thoracic Surgery				
Transplant				
Traumatic Surgery				
Urgent Care/A&E				
Urology				
Vascular Surgery				
Other				

Do any of the above Doctors and/or Surgeons have direct patient care responsibility at the proposers' facilities? (If yes please provide details on the supplementary pages provided) ☐ Yes ☐ No

Healthcare Professionals	Employed		Non- Employed	
Cover Required	Yes	No	Yes	No
Acupuncturists				
Advanced Nurse Practitioners				
Audit Nurses				
Call Handlers				
Clinical Shift Managers				
Clinical Trainees				
Complementary Medicine Doctor				
Dental Nurses				
District Nurses				
Emergency Clinical Physicians				
Health Care Assistants				
Lab Technicians				
Link Nurses				

Healthcare Professionals	Employed		Non- Employed	
Cover Required	Yes	No	Yes	No
Minor Conditions Nurses				
Nurses (Other)				
Nurse Advisors				
Nurse Midwives				
Nurse Practitioners				
Paramedics				
Pharmacists				
Physician Assistants				
Physiotherapists				
Prison Nurses				
Registered Nurses				
Students				
Other				

Do you require that all non-employed medical staff carry their own medical professional liability insurance, or maintain indemnity via a Medical Defense Organisation, if yes please specify limits required. ☐ Yes ☐ No

Limit Required: _____

Do you require that all non-employed medical staff provide evidence of this coverage on an annual basis, as part of your practitioner credentialing process? ☐ Yes ☐ No

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Does the proposer participate in Clinical Research Trials? ☐ Yes ☐ No

If yes, please provide further details outlining the following on the supplementary pages provided.

i. Number of trials
ii. Number of participants
iii. Location of trials performed
iv. Do you receive full indemnity from your principals
v. Are consent forms signed prior to participation in the trial

Does the proposer provide Bariatric Surgery? ☐ Yes ☐ No

If yes, please provide further details outlining the following on the supplementary pages provided.

i. Number of weight loss surgeries per year
ii. Type of weight loss surgery
iii. Do you offer weight loss surgery to patients under the age of 18
iv. Do you require informed consent prior to any surgery
v. What checks do you use to exclude patients

Does the proposer provide Telemedicine? ☐ Yes ☐ No

If yes, please provide further details outlining the following on the supplementary pages provided.

i. Number of encounters per year
ii. Primary (doctor to patient) or Secondary (doctor to doctor)
iii. Countries telemedicine is provided
iv. Do you request indemnity from the institution you are providing secondary telemedicine services to
v. Are clinical protocols followed when providing telemedicine

Does the proposer provide Pharmacy Services? ☐ Yes ☐ No

If yes, please provide further details outlining the following on the supplementary pages provided.

i. Are these services provided to other organisations
ii. Do you have written procedures in place for safety and risk management
iii. Do you use electronic bar-coding
iv. Are you compliant with all relevant regulations

Does the proposer provide Out of Hours or Extended Hours Services? ☐ Yes ☐ No

If yes, please provide further details outlining the following on the supplementary pages provided.

i. Timeframes of when these services are provided
ii. Number of patient visits within these timeframes
iii. Services provided during these timeframes

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RISK & QUALITY MANAGEMENT INFORMATION

Does the proposer utilise a formal written quality management/quality improvement plan? ☑ Yes ☐ No
(If yes, please provide further details on the supplementary pages provided)

Does the proposer utilise a formal risk management plan? ☑ Yes ☐ No
(If yes, please provide further details on the supplementary pages provided)

Are these risk and quality management procedures regularly reviewed and updated to the appropriate standards applicable? ☑ Yes ☐ No

How long has the designated Risk Manager been affiliated with the entity? _____

How long has the designated Quality Manager been affiliated with the entity? _____

Are the roles of the risk manager and quality manager separate? _____

How are medical / patient records stored?

☐ Electronic File ☐ Paper File ☐ Both

If electronic, how often are back-up procedures performed? _____

If paper, are the buildings in which the records are stored fully sprinklered? ■ Yes ☐ No

Do you have facilities for sterilisation of instruments in accordance with relevant guidelines/standards applicable?

☐ Yes ■ No If No, please provide details of how instruments are sterilised on the supplementary pages.

Do you utilise a formal written procedure for the reporting of medical incidents? ☐ Yes ■ No

Do you keep accurate records and ensure all medical professionals hold valid licenses to practise in their respective specialisations issued by the relevant official authority?

■ Yes ☐ No

CLAIM, CIRCUMSTANCE HISTORY

Is the proposer currently aware of, or has been aware of any of the following during the past 5 years?

Any claim, circumstances, complaint, or proceeding brought or threatened against the applicant, or any incident which could lead to such a claim, circumstances, complaints or proceedings?

■ Yes ☐ No

Any investigations, or adverse findings by any professional body, tribunal, regulatory or registration body?

☐ Yes ■ No

Declinature, termination, non-renewal or special conditions imposed by previous or current Insurers?

■ Yes ☐ No

If the answer to any of the above questions is Yes, please provide the following information, preferably in an Excel Spreadsheet.
All values should include any deductible paid by the proposer.

- Claimant Name
- Incident Date & Notification Date
- Indemnity Reserve
- Legal costs and expenses incurred
- Description of the Claim
- Date of Closure

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PREVIOUS INSURANCE HISTORY

Who are the present Medical Professional Liability Insurer's? _____

What are the present policy limits of insurance? _____

What is the amount of self-insured excess/deductible? _____

What is the expiry date of the current policy? _____

Has prior coverage been on a Claims Made basis? ☐ Yes ■ No

DECLARATION

I/we declare that I/we have made a fair presentation of the risk by disclosing all material matters which I/we know or ought to know or, failing that, by giving the Insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries in order to reveal material circumstances.

Signature _____

Name (please print) _____

Position _____

Date _____