Logo

Description automatically generated with medium confidence

FERTILITY CLINICS

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: |  |

Please provide your HEFA Licence number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you operate as a satellite clinic, please provide the name and licence number together with the name and HFEA License number with whom you are affiliated:

|  |
| --- |
|  |

Please list the associations, professional bodies and regulatory organisations with whom you hold a licence/membership

|  |
| --- |
|  |

Has your membership or registration with any of the above bodies ever been refused, suspended, withdrawn or had conditions issued/imposed

Yes  No

|  |
| --- |
|  |

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)

1. Obtain another operation or entity Yes  No
2. Increase the number of employees Yes  No
3. Expand the number of locations Yes  No
4. Eliminate/Add current services Yes  No
5. 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

Please provide the number of IVF cycles you performed in the last 12 months and an estimate number for the next 12 month period:

|  |  |  |
| --- | --- | --- |
| Past Financial Year | Current Financial Year | Next Year (Estimated) |
|  |  |  |

Is all donor semen screened, cryopreserved and quarantined in line with current HFEA code of practice

Yes  No

Does the proposer participate in Clinical Research Trials

Yes  No

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

1. Number of trials
2. Number of participants
3. Location of trials performed
4. Do you receive full indemnity from your principals
5. Are consent forms signed prior to participation in the trial

Please state the total number of persons involved in the following capacities

|  |  |  |  |
| --- | --- | --- | --- |
| Artificial Insemination by Donor |  | Intrauterine Insemination (IUI) |  |
| Artificial Insemination by Husband (AIH) |  | In Vitro Fertilisation (IVF) |  |
| Assisted Hatching |  | In Vitro Maturation (IVM) |  |
| Counselling Services |  | Pronuclear Stage Embryo Transfer (PROST) |  |
| Egg Collection/Harvesting |  | Storage of Embryos |  |
| Egg Donation |  | Storage of Gametes |  |
| Embryo Transfer |  | Storage of Semen for Oncology Patients |  |
| Frozen Embryo Transfer (FET) |  | Surgical Sperm Retrieval (SSR) |  |
| Gamete Intra-Fallopian Transfer (GIFT) |  | Tubal Embryo Transfer (TET) |  |
| Genetic Screening |  | Other (please specify) |  |
| Intracytoplasmic Sperm Injection (ICSI) |  |  |  |

Medical Practitioners

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Occupation | Employed | | Non- Employed | | Occupation | Employed | | Non- Employed | | |
| Cover Required | Yes | No | Yes | No | Cover Required | Yes | No | Yes | No |
| Medical Practitioners |  |  |  |  | Nurses |  |  |  |  |
| Embryologists |  |  |  |  | Anaesthetics |  |  |  |  |
| Radiographers |  |  |  |  | Sonographers |  |  |  |  |
| Counsellors |  |  |  |  | Healthcare Assistants |  |  |  |  |
| Laboratory Technicians |  |  |  |  | Clerical/Administration |  |  |  |  |

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

Does the proposer provide Pharmacy Services

Yes  No

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

1. Are these services provided to other organisations
2. Do you have written procedures in place for safety and risk management
3. Do you use electronic bar-coding
4. Are you compliant with all relevant regulations

RISK & QUALITY MANAGEMENT INFORMATION

Does the proposer utilise a formal written quality management/quality improvement plan (*If yes, please provide further details on the supplementary pages provided*).

Yes  No

Does the proposer utilise a formal risk management plan (*If yes, please provide further details on the supplementary pages provided).*

Yes  No

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

PREVIOUS INSURANCE HISTORY

Who are the present 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 enqueries in order to reveal material circumstances

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_