HDL HEALTHCARE DIVISION HORSELL DUFFY LANGLEY

MEDICAL PRACTICE INDEMNITY INSURANCE PROPOSAL FORM

IMPORTANT NOTICE

Completing this Proposal Form does not mean that you will automatically be granted insurance cover proposed. However, if insurance is granted, it will be based upon representations you give us. Should any particulars given have changed or be incorrect you must notify us immediately. We reserve the right to revise or withdraw any insurance granted at any time subject to any changes in such particulars.

Role of Horsell Duffy Langley Pty Limited

Horsell Duffy Langley Pty Limited AFSL 422018 | ABN 12 155 940 604 has entered into an arrangement with the Underwriter to provide this product. We may act as either agent of the Insured or wholesale broker to the representative of the Insured. Where we operate as a wholesale broker, we are acting on the information provided to us and provide no advice in respect to the appropriateness of the coverage and suitability of the insurance for the policy holder. Where we act as wholesale brokers, the Insured should refer to their broker for advice

The Insurer

Certain underwriters at LLoyd's.

Duty of Disclosure

Before you enter into a contract of general insurance with an Underwriter, you have a duty, under the Insurance Contracts Act 1984, to disclose to the Underwriter every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of general insurance, Your duty however does not require disclosure of any matter:

- that diminishes the risk to be undertaken by the Underwriter;
- that is of common knowledge;
- that your Underwriter knows or, in the ordinary course of its business, ought to know;
- as to which compliance with your duty is waived by the Underwriter.

It is important that all information contained in this proposal is understood by you and is correct, as you will be bound by your answers and by the information provided by you in this proposal. You should obtain advice before you sign this proposal if you do not properly understand any part of it. Your duty of disclosure continues after the proposal has been completed up until the contract of insurance is entered into.

Non –Disclosure
If you fail to comply with your duty of disclosure, the Underwriter may be entitled to reduce its liability under the contract in respect of a claim or may cancel the contract. If your non-disclosure is fraudulent, the Underwriter may also have the option of avoiding the contract from its beginning.

Change of Risk or Circumstances

You should advise Horsell Duffy Langley as soon as practicable of any material change to your normal business as disclosed in the proposal, such as changes in location, acquisitions and activities.

Privacy Statement

Only in this statement "we", "us" and "our" means Lloyd's and Horsell Duffy Langley Pty Limited as its agent.

We are bound by the obligations of the Privacy Act 1988 as amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.

Our Privacy Policy, available at www.HDLbrokers.com.au or by calling us, sets out how:

- we protect your personal information;
- you may access your personal information;
- you may correct your personal information held by us;
- you may complain about a breach of the Privacy Principles or Registered Privacy Code and how we will deal with such a complaint.

We need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers - including reinsurers - and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). It is likely that the information will be disclosed overseas.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insured's). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting Horsell Duffy Langley.

HDL HORSELL DUFFY LANGLEY HEALTHCARE DIVISION

Instructions

This Application and all materials submitted shall be held in confidence.

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

If a question does not apply, please write "N/A". If the answer is none, state "none". If more space is needed, please continue on a separate sheet of the applicant's letterhead and indicate the question number to which the information responds. This Application and any separate continuation sheets must be completed, signed and dated by a principal of the business.

Applicant Information

1. Name of Insured(s) to be covered: ABN/ACN:

2. Trading Names

3. How many years has the applicant been in operation?

4. Address and contact details of principal office:

Contact Name:

Street Address: State:

Suburb: Postcode:

Telephone: Email:

Website:

5. List addresses of all locations you operate from:

6. Is the applicant an accredited facility? ☐ Yes ☐ No

Accrediting body:

Date Last Year Accreditation awarded:

7. Please give details of your current and previous medical malpractice insurance.

Current Year

Insurance Company:

Limits of Liability: Deductible:

Basis of Current Insurance Cover: ☐ **Claims-Made** - Retroactive Date: ☐ **Occurrence**

Previous Year

Insurance Company:

Limits of Liability: Deductible:

8. Requested commencement date of Cover.

9. What 'Any One Claim' Limit of Indemnity does the applicant require?

☐ 2m ☐ 5m ☐ 10m Other (specify)

10. What Aggregate Limit of Indemnity does the applicant require?

☐ 2m ☐ 5m ☐ 10m Other (specify)

11. Indicate the gross revenue from applicant's facility(ies):

Prior Year: Current Year: Projected:

12. Organisation Type: ☐ For Profit ☐ Not for Profit

13. On the following page, please Indicate all services provided by choosing all that apply:

This information is the basis for rating the submission. If the response includes other, provide receipts and treatments. Annual # of Procedures are defined as the number of patients entering the facility for health-related services per year. Where a service includes contacts falling into more than one of the below classifications (for example, telephone triage followed by out of hours visit), please only complete the main classification:

Type of Centres	Services Provided	Annual # of Procedures
Surgery Centres	Cardiac: Catheterisation	
	Cardiac: Other (describe on following page)	
	Chiropractic: Other (describe on following page)	
	Dental, Oral and Maxillofacial	
	Endoscopy / Colonoscopy	
	Gastro-Intestinal / GI Surgery	
	Gynaecologic Surgery	
	Injection (Joint, Spinal, Trigger)	
	Liposuction	
	Ophthalmology: LASIK procedures	
	Ophthalmology: Other than LASIK	
	Orthopaedics	
	Plastic / Aesthetic Surgery	
	Podiatric Surgery	
	Urological Surgery	
	Weight Loss Surgery	
	Other: (describe on following page)	
Imaging Centres	CT	
	MRI	
	PET	
	Ultrasound: Obstetric	
	Ultrasound: (non-Obstetric)	
	X-Ray	
	Other: (describe on following page)	
Laboratories	Cytology	
	DNA/Genetic Testing	
	Endocrinology	
	Haematology	
	Paternity Testing	
	Pathology	
	Research	
	Sperm Bank	
	Toxicology	
	Other: (describe on following page)	
Multi- disciplinary Clinics		

Type of Centres	Annual # of Procedures
Cancer Treatment Centres	
Diagnostic Clinics	
Dialysis	
Drug & Alcohol Rehabilitation Centres	
Pharmacies	
Physical Rehabilitation	
Walk-in Clinics	

Type of Centres		
Hospices / Palliative Care	# of beds:	
Nurse staff	Full time Equivalent (FTE) Nurses placed:	

Where requested on previous page, please describe:

14. Do you provide services to foreign nationals? If yes, what percentage are:

US Residents _____ %

15. Supervising Doctors/Dentists/Dental/Oral Surgeons

Specialty	Total Number of Registered Medical/Dental Practitioners	Full time Equivalent (FTE) 1 FTE - 40 hours/week	Full time Equivalent (FTE) Independent Contractor

16. Are there any registered medical/dental practitioners that are not members of medical/dental defense organisations and are not fully indemnified for their own malpractice nor are otherwise insured for all work undertaken on your behalf?

Employed? ☐ Yes ☐ No

Independent Contractor? ☐ Yes ☐ No

If 'Yes', please explain:

17. Have any of employed/self-employed doctors/dentists been subject of disciplinary proceedings for professional misconduct? ☐ Yes ☐ No

If 'Yes', please explain:

18. Healthcare Professionals. Please list all employed and contracted healthcare professionals and their specialisation. (Attached list if insufficient room).

Specialty	Total Number	FTE Employed	FTE Independent Contractor

Do you have nurse practitioners on site with prescriptive authority? If yes, provide the number:

19. Please provide details of any new activities or developments that are likely to occur within the next 12 months (i.e. new construction projects or new clinical programs). If none, state "none".

20. Clinical trials: Does the applicant sponsor any clinical trials? ☐ Yes ☐ No

21. Are there any known contractual obligations where the Applicant has to provide insurance on behalf of another medical provider or hold another medical provider harmless? ☐ Yes ☐ No

If yes, list and state purpose:

22. Does the applicant work with Professional Athletes? ☐ Yes ☐ No

If yes, please provide a description.

23. Please complete the following to the best of the Applicant's knowledge at the time of signing the Application:

a. Does the applicant have a formal written Risk Management Process in place? If yes, please provide the latest report provided to the governing body,if applicable, and a brief description of the internal reporting process. ☐ Yes ☐ No

b. Procedures for formal incident reporting are clearly documented and implemented throughout the Applicant's organisation. ☐ Yes ☐ No

c. Is there a formal medical record (electronic or paper) retention policy or process in place? ☐ Yes ☐ No

d. Is a patient complaint management procedure in place and appropriately reported to senior executives? ☐ Yes ☐ No

e. Formal mechanisms are in place for selection, recruitment, orientation, and performance management of all employees and independent medical staff. ☐ Yes ☐ No

f. Is there a formal mechanism in place for credentialing and privileging of medical staff? ☐ Yes ☐ No

g. The Applicant is in compliance with all regulatory workplace health & safety requirements ☐ Yes ☐ No

h. The applicant disposes of all waste in accordance with regulatory requirements ☐ Yes ☐ No

i. The Applicant sterilises instruments in accordance with current best practices guidelines ☐ Yes ☐ No

j. Applicant complies with manufacturer guidelines with respect to single-use products, devices or equipment ☐ Yes ☐ No

24. Does the Applicant/Company have locations, operations or employees outside of the Applicant's domiciled country or other? If yes, please provide details: ☐ Yes ☐ No

For each of the following questions, if you answer "Yes", please provide details on a separate sheet and attach to the application.

26. Has the applicant had any medical professional, or general liability claims or suits brought against it in the past 5 years? ☐ Yes ☐ No

27. Is the applicant aware of any incident, circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No

28. Has the facility/operational registration ever been suspended, revoked or voluntarily suspended? ☐ Yes ☐ No

29. Has any insurance Insurer or Lloyd's Syndicate declined, cancelled, or refused to renew or accept any of the applicant's liability insurance? ☐ Yes ☐ No

30. Has any company with whom the applicant has been previously affiliated, become insolvent? ☐ Yes ☐ No

31. Has the applicant or any of its officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by any professional medical society, accreditation agency, or other governmental or non-governmental oversight entity? ☐ Yes ☐ No

Please enclose any lists or explanations as required in response to various questions throughout the body of the insurance Proposal. In addition, please provide copies of the following:

- **Claim loss runs for the past five (5) or more years for all coverages for which you are applying, in Excel format, if available.**
- **Sample contract reflecting applicant's requirements for indemnification and liability insurance coverages from other parties.**

Declaration

On behalf of the proposed insured, I / we declare that the answers given herein are in every respect true and correct and that I / we have not withheld any information likely to affect the acceptance of this insurance and that I / we have read and understood the Policy document. I / we have sought clarification of any aspects of the proposal form or Policy document I / we did not understand.

I / we acknowledge that the Insurer may give to, and obtain from, other insurers, personal information of mine/ours relating to this insurance as well as insurance claims information obtained during the course of any contract I / we have with the Insurer.

I / we also acknowledge that the Insurer is not obliged to automatically accept the insurance proposed above, however the Insurer will formally advise me / us of the extent to which they are prepared to offer insurance by quotation, schedule or otherwise in writing.

Signature in Full

Name (Please print)

Position in Company (Please print) Dated:

A copy of this proposal form should be retained by you for your records.

HDL HEALTHCARE DIVISION HORSELL DUFFY LANGLEY

Horsell Duffy Langley Pty Limited
ABN 12 155 940 604 AFSL 422018

www.HDLbrokers.com.au

Suite 1005, Level 10
4 Bridge Street Sydney NSW 2000

P: +61 2 8488 8380
E: info@HDLbrokers.com.au