

Individual Practitioners
Private Practice Proposal Form

When you apply for membership of OTSIS and for an insurance policy with the MPI Group, you will be asked to provide details about the scope of your practice, the number of sessions you work in the NHS and independent sector and any previous claims against you. Based on this information, your risk will be assessed against standardised criteria and your subscription rate shall be calculated.

Please ensure you complete and send back the following so we can progress your application:

1. a completed, signed and dated Proposal Form and Orthopaedic Addendum, and
2. a completed, signed and dated Letter of Authority.

For enquires about your application, please contact the MPI Group office on: 0300 3033 531

Either type in the fields on this form after saving it to your computer, then print out and sign the form, or print out the form and complete it by hand.

You can e-mail completed forms to: newenquiries@mpi.group

Or you can send them to:

OTSIS

Medical Professional Indemnity Group

Plough Court,

37 Lombard Street,

London,

EC3V 9BQ

IMPORTANT NOTICE TO THE PROPOSER ABOUT THE COMPLETION OF THIS PROPOSAL FORM

# Disclosure

The information provided in answers to the questions contained in this proposal form will be used by the underwriters to determine whether to provide you with the insurance requested and the terms of such insurance, including setting the premium payable.

You have a duty to take reasonable care to ensure that you do not make any misrepresentations to the Insurer(s) when answering these questions, as the Insurer will rely on the accuracy of your responses. This may mean that you will need to check your records in order to provide an accurate response.

If you do not answer any questions honestly, accurately or withhold information, the Insurer may refuse to pay your claim, pay only part of your claim, and/or avoid your policy. If the Insurer obtains evidence that you deliberately or recklessly provided incomplete or untrue answers to the questions set out in this form, the Insurer will not pay out on any claims and may in fact demand repayment of any claims already paid. In some cases, the Insurer may not return the premium to you.

Please answer all of the questions in this proposal form completely and truthfully to the best of your knowledge and belief, having made full enquiry.

# Presentation

This Proposal Form must be completed by the proposed individual. All questions must be answered. If there is insufficient space to provide answers additional information should be provided on the proposer’s letter headed paper.

Failure to present the Insurer with information may adversely influence the ability of the Insurer to offer terms.

# Guidance

If in doubt as to the meaning of any question contained within this proposal form or the issues raised in
*Disclosure* and/or *Presentation* above, advice should be sought from the MPI Group office in the first instance by calling 0300 3033 531.

SECTION A – YOUR PERSONAL DETAILS

|  |  |  |
| --- | --- | --- |
| Title:  | Forename(s):  | Surname:  |
| Any other name(s) previously used:  | **Date of Birth:**  |
| Nationality:  | Male [ ]  Female [ ]  |
| Home AddressHouse No. Address 1: Address 2: Address 3: Address 4: Town: Country: Postcode: Tel No.  | Practice Address:Line 1: Line 2: Line 3: Line 4: Line 5: Town: Country: Postcode: Work No.  |
| Mobile No:  | Email address :  |
| Registration Body:  | Registration Number:  |
| GMC Registration Date:  | Are you on the Specialist Register Yes [ ]  No [ ]  |

SECTION B – ACADEMIC DETAILS

|  |  |
| --- | --- |
| Country of Qualification:  | Year of Qualification:  |
| Medical School:  |
| Post Graduate Qualifications:  |
| Are you a Member of any specialty associations or organisations? Yes [x]  No [ ]  If so which…………….  |
| Details of NHS position(s) held over the last 10 years including name of trust, title held and length of service:  |

SECTION C – ACTIVITIES

|  |
| --- |
| 1. Please provide details of the procedures you undertake in private practice on the Orthopaedic Addendum to this form:

Enclosed [ ]  Not Enclosed [ ]  |
| 1. Please Provide the % breakdown of your private work between the following categories:

|  |  |  |
| --- | --- | --- |
| Private Practice |  | % |
| Medico-legal reports |  | % |
| NHS outsourced work for which you require an indemnity |  | % |
| Other |  | % |
| **TOTAL** | **100** | **%** |

 |
| 1. Please advise the date that you started private practice (month and year)

 Month: Year:  |
| 1. Please advise which Private Hospitals you have admitting rights to:
 |
| 1. Please provide income figures by financial year (please give month/year) for the following:-

|  |  |  |
| --- | --- | --- |
|  | Projected Income for the **NEXT** Accounting Year ending (estimate) / **(*MONTH/YEAR)*** | Income for your **LAST complete** Accounting Year ending (actual) / **(*MONTH/YEAR)*** |
| Total Gross Annual Income from Private Practice (Excl. Medico-legal work & non-indemnified NHS work) | £ | £ |
| Total Gross Annual Income from non-indemnified NHS work, e.g. NHS Waiting List Initiative(s) or Choose & Book (NHS e-Referral Service) | £ | £ |
| Total Gross Annual Income from Medico Legal Work  | £ | £ |

 |
| 1. If you do require indemnity for any non-indemnified NHS Waiting List Initiative(s) or Choose and Book (NHS e-Referral Service) work, please state the name of the hospital where you carry out this type of work:
 |
| 1. Please provide an estimate of the TOTAL NUMBER of PRIVATE PRACTICE procedures and consultations you undertake per annum: *(please note that this should tally with the figures advised in the Addendum to this form)*

|  |  |
| --- | --- |
| Total Number of Private Practice Procedures including Consultations |  |

 |
| 1. Please advise an estimated split per annum between the following (patient contact, not income):

|  |  |  |
| --- | --- | --- |
| In-Patient Procedures |  | **%** |
| Out-patient Procedures |  | **%** |
| Consultations |  | **%** |

 |
| 1. Please give details of the breakdown of your PRIVATE PRACTICE as follows:

|  |  |  |
| --- | --- | --- |
| **Private Hospital Group** | **Proportion of Total Gross Annual Income** | **Proportion of all Procedures and Consultations** |
| **Spire** | % | % |
| **BMI** | % | % |
| **Circle** | % | % |
| **Nuffield** | % | % |
| **Ramsey** | % | % |
| **HCA** | % | % |
| **Private work in an NHS Hospital (please state hospital)** | % | % |
| **Hospital of St John and St Elizabeth** | % | % |
|  | **100%** | **100%** |
|  |  |  |

 |
| 1. Do you undertake any private practice work in an NHS hospital? Yes [ ]  No [ ]

 If yes, please advise an estimated split between the following:

|  |  |
| --- | --- |
| Private Wing of NHS hospital |  % |
| NHS Waiting List Initiative |  % |

 |
| 1. Do you undertake any paediatric work? Yes [x]  No [ ]

 If yes, please provide an estimated percentage of paediatric work for both Private Practice and NHS work:

|  |  |
| --- | --- |
| Private Practice | % |
| NHS | % |

 |
| 1. Do you own or operate a Hospital, Nursing Home, Clinic, Laboratory, Day Surgical Centre or similar facility?

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |
| --- |
|  |

 |
| 1. Are you registered as a data controller under the Data Protection Act?Yes [ ]  No [ ]
 |
| 1. Do you operate a Limited Company, LLP or similar joint venture?

**Yes** [ ]  **No** [ ]  **If Yes, please advise the company name and number.**

|  |  |
| --- | --- |
| **Company Name** |  |
| **Company Number** |  |

1. Is this purely for fiscal reasons?

Yes [ ]  No [ ]  1. Does your company employ any staff? *(e.g. nurse, secretary)*

Yes [ ]  No [ ]  If Yes, please detail these below:

|  |
| --- |
|  |

1. Are there any other medical or healthcare practitioners associated with your limited company? e.g. as a director. If yes, please give details below:

**Yes** [ ]  **No** [ ]

|  |
| --- |
|  |

 |
| 1. Do you directly employ or engage any professional staff for whom you are responsible? (i.e not through your company or any other legal entity)

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |  |  |
| --- | --- | --- |
| Name | Role | Qualifications |
|  |  |  |

Do they maintain their own indemnity: Yes [ ]  No [ ]   |
| 1. Do you undertake any other work for which you require indemnity?

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |
| --- |
| *If “Yes” please include details of their name/s, their role/s and qualifications and confirmation of whether they maintain their own indemnity* |

 |
| 1. Are you involved in clinical trials for which you require cover?

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |
| --- |
| *Please contact OTSIS if you require cover for any forthcoming clinical trials – no cover is in place until the underwriters have accepted this.* |

 |
| 1. Do you have any high profile clients or undertake work on any high profile people (defined as any person who is in the public eye or whose income is generated by public / media appearances)

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |
| --- |
| If “Yes” please include details of their profession / status, type of treatment provided, average frequency of high profile patients seen per annum. Confirmation of whether you have any formal or informal agreements in place. If so, please provide a copy of the contract(s). |

 |
| 1. Do you undertake any type of work for any professional sports club or for professional sports people?

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |
| --- |
| If “Yes” please include details of the sports profession / club, level of standard, type of treatment provided, average frequency of sports persons seen per annum, and whether you provide any pitch side first aid for sporting events. Confirmation of whether you have any formal or informal agreements in place. If so, please provide a copy of the contract(s). |

 |
| 1. Are you involved in any clinical activities outside the United Kingdom, the Channel Islands or the Isle of Man?

 Yes [ ]  No [ ]  If “Yes” please provide full details below.

|  |
| --- |
| If “Yes” please include details of the location of activities and average length of time spent overseas. |

 |
| 1. Are you involved in any form of complementary or alternative medicine?

 Yes [ ]  No [ ]  If “Yes” please provide full details below. |
| 1. Do you plan to retire from either private practice or NHS activities, wind down your practice or permanently relocate overseas in the next 5 years?

 Yes [ ]  No [ ]  |

SECTION D – GENERAL QUESTIONS

Please provide the following details in relation to both NHS and PRIVATE PRACTICE:

|  |
| --- |
| 1. Are you aware of any complaints or claims that have been brought against you, including any closed or settled matters?

 Yes [ ]  No [ ]   |
| 1. Are you aware of any circumstances that could lead to any disciplinary action or suspension?

Yes [ ]  No [ ]  |
| 1. Have you ever been subject to an investigation or disciplinary action at any time by any regulator, employer or healthcare trust either in the UK or abroad which resulted in a suspension, conditions of practice, removal from the register, a warning or where no action was taken?

Yes [ ]  No [ ]   |
| 1. Are you aware of any complaints or circumstances that may give rise to a claim or disciplinary action against you?

Yes [ ]  No [ ]   |
| 1. Have you ever been the subject of a Medical Defence Organisation’s adverse member procedure?

Yes [ ]  No [ ]   |
| 1. Has any Medical Defence Organisation or insurance indemnity provider ever declined to offer you membership or insurance, cancelled or terminated membership or insurance, imposed special terms or refused renewal?

Yes [ ]  No [ ]  |
| 1. Have you ever been convicted of a criminal offence or received a formal police caution?

Yes [ ]  No [ ]  |

|  |
| --- |
| If you have answered “Yes” to any of Section D, please can you provide full details on the blank page at the end of the form including the following information:-* **Date of incident(s);**
* **A summary of the events, including all relevant details such as your involvement;**
* **What action you took, including any involvement from your indemnity provider;**
* **What action the employer, regulator or trust took against you, including any sanctions imposed;**
* **Information on any payments made on your behalf for either legal costs or indemnity payments**
 |

SECTION E – INDEMNITY

Please advise the following:

|  |  |
| --- | --- |
| 1. Please advise the first day that cover is required:

|  |
| --- |
|  |

 |
| 1. Please provide full details of previous cover – please include all since qualification

|  |  |  |  |
| --- | --- | --- | --- |
| **Insurer / Indemnity Provider** | **Start Date** | **Limit of Indemnity** | **Current Subscription** |
|  |  | £ | £ |
|  |  | £ | £ |
|  |  | £ | £ |
|  |  | £  |  |

 |
| 1. The standard Limit of Indemnity for OTSIS members is £10 million for any one claim and in the annual aggregate, costs inclusive. If you require a higher Limit, please call the OTSIS office: 0300 3033 531
 |
| 1. What level of Excess would you prefer?

 Nil [ ]  £5,000 [ ]  £10,000 [ ]  £25,000 [ ]  Other, please state £………………………………………..  |
| 1. Has prior cover been on a CLAIMS MADE basis?

Yes [ ]  No [ ]  Don’t know [ ]  If “Yes” what are the retroactive dates

|  |
| --- |
|  |

 |
| 1. Has any proposal for similar insurance or indemnity ever been declined or has such insurance or indemnity ever been cancelled, refused or had any special terms imposed (other than general market increases)?

Yes [ ]  No [ ]  If “Yes” please provide details below

|  |
| --- |
|  |

 |

SECTION F – CONSENT

|  |  |
| --- | --- |
| Please confirm that you always comply with the GMC’s guidance on consent, and undertake the following: * accurately and comprehensively recording pre-operative discussions with patients;
* discussing alternatives to treatment, including the option of no treatment (if appropriate);
* recording and keeping copies of all information sheets given to patients and ensuring that all information sheets provided are user friendly;
* allow for a cooling off period prior to the procedure (if appropriate);
* not delegating the responsibility to obtain informed consent to any other party;
* ensuring that the patient signs and dates the consent form prior to treatment, including an acknowledgement from the patient that all risks have been discussed and understood and the patient has received any relevant information sheets;

Yes [ ]  No [ ]  If “No” please provide details below

|  |
| --- |
|  |

 |

|  |
| --- |
| **Please use this space to record the answers to any questions for which you require additional space, noting the appropriate question number:**  |
|  |

OTSIS Addendum:

Please provide the following details:

|  |  |
| --- | --- |
| 1. **Please advise if you are employed by the NHS as a Consultant Orthopaedic Surgeon**
 | **Yes** [ ]   **No** [ ]  |
| 1. **PREVIOUS YEAR’S PROCEDURES: Please state your activities related to Private (Non Indemnified and NHS (Indemnified) work**
 |
| **AREA OF SURGERY** | **Your expertise in this field would be described as:** | **Please provide a breakdown of the number of the following procedures you undertook in your private practice in the last complete financial year year** | **Approximate % of your work in each area of surgery in Private Practice and NHS** |
|  | **Major** | **Minor** | **None** |  | **Private Practice** | **NHS** |
| Hip |  |  |  |  | 0%  | 0%  |
| Knee |  |  |  |  | 0%  | 0%  |
| Ankle/Foot |  |  |  |  | 0%  | 0%  |
| Spinal |  |  |  |  | 0%  | 0%  |
| Trauma |  |  |  |  | 0%  | 0%  |
| Shoulder |  |  |  |  | 0%  | 0%  |
| Elbow |  |  |  |  | 0%  | 0%  |
| Wrist/Hand |  |  |  |  | 0%  | 0%  |
| Sports Injuries |  |  |  |  | 0%  | 0% |
| Cancer Surgery |  |  |  |  | 0%  | 0%  |
| Other |  |  |  |  | 0% | 0% |
|   |  |  |  |  | 0% | 0% |
| 1. **ANY NEW PROCEDURES: Will you be performing any new procedures**

 **in the next 12 months?** | **YES/NO** |  |
| **If yes, please confirm the type of procedure and in addition, please confirm the following:***Confirmation of whether you perform the procedure in the NHS, if yes, please confirm your experience of performing the procedure including details of where/ when you trained, number of years’ experience and approximate number of procedures you’ve provided in the NHS and in Private Practice.* |
| 1. **Please advise if you have ever undertaken individually or as part of a team any form of spinal surgery or treatment?**
 | **Yes** [ ]   **No** [ ]  |
| 1. **Do you use or have you ever used Metal on Metal hip implants?**
 | **Yes** [ ]   **No** [ ]  |
|  **If ‘yes’ please provide the following:** |  |
| **Number of procedures where Metal on Metal hip implants were used** |  |
| **Have you stopped using Metal on Metal hip implants?** | **Yes** [ ]   **No** [ ]  |
| **Date last used** |  |

**DECLARATION**

I declare that the statements and particulars contained in this proposal form and addendum are true and accurate to the best of my knowledge and belief and that I have not mis-stated, suppressed or omitted any information which is, or might reasonably be expected to be, relevant to the decision of the Insurer when setting the terms of the insurance.

I understand that the Insurer will rely on the information contained in this proposal form and addendum together with any other information supplied by me when setting the terms of the insurance, including the premium.

I undertake to inform Insurers as soon as practicable if I become aware of any material change to the answers set out in this form occurring before completion of the contract of insurance. However, I understand that my duty to disclose material changes to this information continues after the completion of the proposal form and addendum and throughout any period of insurance (and any extension).

You should keep a record of all the information you have given to the Insurer, including a copy of this proposal form and addendum and any attachments.

Signing this proposal does not bind the proposer to complete this insurance.

|  |  |
| --- | --- |
| Signature  | Printed name |
| Date  |  |

***Data Protection Act*** *– All personal information supplied by you will be treated in confidence by W.R. Berkley UK Ltd, Ltd and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of W.R.Berkley UK Ltd or our agents or subcontractor.*

**TO WHOM IT MAY CONCERN**

Dear Sirs

**LETTER OF APPOINTMENT AND AUTHORITY TO REPORT**

This letter is to confirm that I have appointed the brokers for OTSIS, Gallagher, trading as Medical Professional Indemnity Group, of Plough Court, 37 Lombard Street, London, EC3V 9BQ to act as my Insurance Broker in respect of professional medical indemnity.

Please provide MPI Group with any information and documentation they may require including, if requested, Confirmed Claims Experience, copy Proposal Forms and copy Policy Documents.

Yours faithfully,

Date:

Name:

GMC Number: