BSE Insurance Application Form

**This proposal for members of the British Society of Echocardiographers to provide them with insurances required in the conduct of their private practice activities.**

**Cover to be arranged with Hiscox Underwriting Ltd who are authorised and regulated by the Financial Conduct Authority.**

**In deciding whether to accept the insurance and in setting the terms and premium, we have relied on the information you have given us.**

**You must: -**

* **Give a fair presentation of the risk to be insured by clearly disclosing all material facts and circumstances (whether or not subject to a specific questions which you/your senior management and those responsible for arranging this insurance, know or ought to know following a reasonable search;**
* **Take care by ensuring that all information provided is correct, accurate and complete**

**Full Name:**

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| --- | --- |
| **Date of Birth:** |  |

**Trading name (if a Limited Company):**

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**Contact Details:**

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| --- |
| Correspondence Address including postcode: |
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| Registered Address including postcode, if a Ltd Company: |
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| Telephone Numbers:  Home:  Work:  Mobile: |
| E-mail address: |
| Website(if any): |

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| --- | --- |
| **BSE registration number:** |  |

Medical Malpractice and Public Liability (Core Compulsory Covers)

Cover and Premium Options (please select by inserting an X)

|  |  |  |
| --- | --- | --- |
| Limit and Cover | Premium (including 12% Insurance Premium Tax) | Select |
| Medical Malpractice £1M **Non-Invasive** Procedures  Public Liability £1M | £840.00 |  |
| Medical Malpractice £2M **Non-Invasive** Procedures  Public Liability £2M | £1,008.00 |  |
| Medical Malpractice £1M **Invasive** Procedures  Public Liability £1M | £1,232.00 |  |
| Medical Malpractice £2M **Invasive** Procedures  Public Liability £2M | £1,366.40 |  |

The activities covered are as follows:

**NON-INVASIVE** - including Echos, ECG’s, Heart & Blood Pressure monitoring including Ambulatory and Exercise Stress Testing, plus Pacing Follow-Up and Implantable Cardioverter Defibrillator Follow Up

**INVASIVE** - as above plus Contrast Agent Echos and/or Dobutamine Stress Echos only

**1. i) Where did you graduate?**

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| --- |
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|  |  |
| --- | --- |
| **ii) In what year?** |  |

**iii) With what degree, diploma or designation:**

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**2. Details of any additional or post graduate qualifications:**

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**3. Are all tests requested by the patient’s doctor or consultant? Yes/No**

**If NO, please advise below**

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| --- |
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**4. Are all test results given to the patient’s doctor or consultant for interpretation?**

**Yes/No**

**If NO, please advise below**

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**5. Do you provide any medical advice to the patient? Yes/No**

**If Yes, please advise below**

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**6. Full details of what patient records are kept, where & how they are stored and for how**

**long they are retained e.g.**

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**PLEASE NOTE IT IS A REQUIREMENT OF THIS POLICY THAT ALL RECORDS ARE RETAINED FOR A MINIMUM PERIOD OF 5 YEARS AND IN THE CASE OF MINORS, 5 YEARS FROM MAJORITY**

**7.** **What is the total gross annual income from your private work activities: -**

|  |  |
| --- | --- |
| **i) Actual for the last 12 months (if applicable):** | £ |

|  |  |
| --- | --- |
| **ii) Projected for the next 12 months:** | £ |

**PREVIOUS CLAIMS HISTORY**

**8. i) List all claims made against you during the last 10 years. IF NONE, PLEASE STATE “NONE”:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Incident** | **Date of Claim** | **Amount Claimed** | **Amount Paid** | **Amount Outstanding** | **Details including nature of allegations and details of Claimant** |
|  |  | £ | £ | £ |  |

**ii) List all circumstances/complaints which may give rise to a claim being made against you. IF NONE PLEASE STATE “NONE”**

|  |  |
| --- | --- |
| **Date of Circumstance/Complaint** | **Details including nature of the Complaint and details of the Complainant** |
|  |  |

**9. Do you carry, or have carried, malpractice insurance in the last 12 months? Yes/No**

**If Yes please state Name of Insurer:**

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| **Present Limit of Indemnity:** | £ |

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| **Excess under current policy:** | £ |

**What as the retroactive date?**

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| --- | --- |
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**Has any insurer ever cancelled, your medical malpractice insurance policy,**

**declined/refused to renew, or only acccepted the risk at special terms Yes/No**

**If YES, please give details below**

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Employer’s Liability (Optional Cover)

**Is Cover Required? Yes/No**

**Premium is £78.40 including 12% Insurance Premium Tax per employee**

**(including Directors if a Ltd company)**

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| --- | --- |
| 1. **Estimated annual wageroll for the next twelve months**   **(Including Directors if a Ltd company)** | £ |

|  |  |
| --- | --- |
| 1. **Number of Employees (Including Directors if a Ltd company)** |  |

**PREVIOUS CLAIMS HISTORY**

**3. i) List all claims made against you during the last 10 years. IF NONE, PLEASE STATE “NONE”:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Incident** | **Date of Claim** | **Amount Claimed** | **Amount Paid** | **Amount Outstanding** | **Details including nature of allegations and details of Claimant** |
|  |  | £ | £ | £ |  |

**ii) List all circumstances/complaints which may give rise to a claim being made against you. IF NONE PLEASE STATE “NONE”**

|  |  |
| --- | --- |
| **Date of Circumstance/Complaint** | **Details including nature of the Complaint and details of the Complainant** |
|  |  |

Business Contents (Optional Cover)

**Cover available for Medical Devices, Scientific and Computer Equipment at your own premises or whilst temporarily removed anywhere in the United Kingdom up to a total of £10,000**

**Premium is £112.00 including 12% Insurance Premium Tax**

**Is cover required? Yes/No**

**During the last 5 years, have you suffered any loss or damage to Business Property?**

**Yes/No**

**If Yes, please provide details below including date of incident(s), description of loss(es) and amount(s)**

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Declaration

I/we declare and warrant that after enquiry all statements and particulars contained in this proposal are true and that no information whatsoever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/we will advise the Underwriters as soon as practicable. I/we understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect.

I/we hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into

|  |
| --- |
| Date: |

|  |
| --- |
| Signature:  Full Name (please print): |

Cover is subject to underwriting and acceptance. No cover shall be in force until confirmed in writing by us.

**By submitting this application you consent to Partners& using the information we may hold about you or others relating to your policy for the purposes of providing insurance and handling claims, if any, and to process sensitive personal information about you or others related to your policy where this is necessary. This may mean Partners& has to provide such information to third parties such as insurance carriers, third party claims adjusters, fraud detection and prevention services, third party service providers, insurer tracing offices and insurance regulatory authorities.**

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