Plastic, Reconstructive and Aesthetic Surgeons Indemnity Scheme

PRASIS

SPECIALIST TRAINEE SURGEONS MEDICAL MALPRACTICE

PROPOSAL FORM

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INTRODUCTION

The purpose of this application form is for us to find out more about you. Completion of this application form does not oblige either you or us to enter into a contract of insurance.

Following a reasonable search you must provide us with all information which may be material to the cover we offer in a clear and accessible manner. Information is material if it would influence our decision whether to insure you, what cover we offer you or what premium we charge you. If you are in any doubt whether a fact or circumstance is material you should disclose it.

HOW TO COMPLETE THIS FORM

This form should be completed by the applicant who should make all the necessary enquiries to enable our questions to be answered.

If you require extra space to answer the questions or provide any other material information, please use the additional information section at the back of the form. Once you have completed the form please return it directly to your insurance broker.

SECTION 1: PERSONAL DETAILS

1.1 Please provide the following details:

Title:	Full name:
Previous surname (if applicable):	
Gender:	Date of birth: DD / MM / YY
Personal address:	
	Postcode:
Mobile telephone number:	Email:

SECTION 2: QUALIFICATIONS

2.1 Please state:

a) your primary medical qualification, the name of the university you attended and the country where you studied:

Primary medical qualification:	
Name of the university:	
Country:	

b) the year in which you achieved your primary medical qualification:

c) what post graduate qualifications you have attained or any areas of specialist training or fellowships:

d) your GMC Registration Number:

e) the date of your original GMC Registration: MM / YY

f) whether you have passed FRCS (PLAST): ☐ Yes ☐ No

g) your National Training Number:

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h) the anticipated date of your CCT/CCST: DD / MM / YY

i) whether you are a member of any professional association(s): ☐ Yes ☐ No

If yes, please provide full details:

j) whether you participate in any national register(s) or interest group(s): ☐ Yes ☐ No

If yes, please provide full details:

SECTION 3: TRAINING / ASSISTING ROLE

3.1 Please state:

a) the names of your clinical supervisors when training and/or consultants you will or plan to be assisting in private practice:

Consultant name:	Is he/she a PRASIS member?	Your role: Are you training under supervision?	Are you assisting in private practice?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

b) the hospitals where you will be training/assisting:

c) the average number of hours you work per week in private practice and NHS:

Private Practice: NHS:

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d) if you will be paid for assisting and if so what will be your annual income from this role: ☐ Yes ☐ No

If yes, please confirm your expected annual gross income, ***before expenses****:*

e) for any syllabus you have completed, whether you have had any outcome other than Outcome 1 at ARCP? ☐ Yes ☐ No

If yes, please provide full details:

SECTION 4: AESTHETIC PRACTICE

4.1 Please state if you have ever undertaken any aesthetic work? ☐ Yes ☐ No

If yes, please provide full details including the nature of your activities, where you have been providing these services, the length of time you have been doing this and who indemnified you for this work: *Please continue on the ADDITIONAL INFORMATION page if necessary.*

Procedures undertaken	Place of work e.g. clinic name	Date you commenced these activities	Indemnity provider

4.2 Do you plan to undertake any aesthetic work for which you require indemnity under this policy? ☐ Yes ☐ No

If yes, please state:

Procedures undertaken	Number of procedures per annum	Number of months' / years' experience in this field	Products used
Botox – face:			
Botox – platysmal bands:			
Botox - other (please state below):			
Chemical peels:			
Dermal Fillers – permanent:			
Dermal Fillers – semi-permanent:			
Dermal Fillers – temporary:			
Dermabrasion:			

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4.3 Do you undertake any periorbital fillers? ☐ Yes ☐ No

If yes, please state the number of fillers performed per year to:

Upper lid: Lower lid: Tear-trough :

4.4 Please state what additional training you have undertaken for your aesthetic work including all courses and the dates of completion?

4.5 Please state your expected annual gross income (**before expenses**) from aesthetic work for the current year: £

SECTION 5: OTHER ACTIVITIES

5.1 Do you provide any remote prescribing services: ☐ Yes ☐ No

If yes, please provide full details of these services:

5.2 Please state whether you undertake any work overseas: ☐ Yes ☐ No

If yes, please provide the following information in respect of each planned overseas trip during the next 12 months:

Country	Nature of medical and clinical professional services	Dates and duration of the trip

5.3 Please state whether you undertake any charity work/out of programme experience for which you require cover under this Policy: ☐ Yes ☐ No

If yes, please provide full details of where the work is undertaken and the organisations you are working for:

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5.4 Do you plan on undertaking any other work (not listed above) for which you require cover under this Policy: ☐ Yes ☐ No

If yes, please provide full details of these activities:

5.5 Please state whether you are registered as a data controller under the Data Protection Act: ☐ Yes ☐ No

If you hold personally identifiable data on your own electronic system you must be registered with the Information Commissioners Office.

If you hold electronic data on your patients, please state whether you:

a) have anti-virus software installed and enabled on all of your IT equipment, including desktops, laptops and servers (excluding database servers) and confirm that it is updated on a regular basis: ☐ Yes ☐ No

b) have firewalls installed on all external gateways: ☐ Yes ☐ No

c) take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or whether your outsourced service provider meets this requirement: ☐ Yes ☐ No

SECTION 6: INDEMNITY HISTORY REQUIREMENTS

6.1 Please provide details of your current and previous indemnity arrangements covering you and what you now require for this insurance or otherwise provide copies of your previous arrangements:

	Retroactive date	Start date	Limit of cover	Excess	Premium	Medical defence organisation/ Insurer
Previous:	MM / YY	MM / YY				
Previous:	MM / YY	MM / YY				
Previous:	MM / YY	MM / YY				
Current:	MM / YY	MM / YY				

SECTION 7 : CLAIMS EXPERIENCE

7.1 Please answer the following questions in relation to any NHS work, any private work whether under supervision or not and any aesthetic work. Please consider all relevant information and if in doubt, refer to your broker. Regarding all of the types of insurance to which this application form relates.

After full enquiry:

a) have you **ever**:

i. been subject to any form of disciplinary action or investigation? ☐ Yes ☐ No

ii. been subject to or involved in any claim, complaint or allegation of negligence (even if the outcome was in your favour)? ☐ Yes ☐ No

iii. been subject to any conditions or suspension to practice by any employer or educational institution? ☐ Yes ☐ No

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iv. been subject to any adverse findings, conditions, suspension or erasure by a regulator, registration body or equivalent? ☐ Yes ☐ No

b) are you aware of any incidents or circumstances which may lead to:

i. any claim, complaint or allegation of negligence? ☐ Yes ☐ No

ii. disciplinary action or suspension? ☐ Yes ☐ No

iii. conditions or restriction on your role? ☐ Yes ☐ No

iv. removal of your name from a Professional or Regulatory Register? ☐ Yes ☐ No

v. any investigation by a regulator, registration body or equivalent? ☐ Yes ☐ No

c) in relation to your role, have you ever suffered a loss of data that has resulted in a privacy breach? ☐ Yes ☐ No

d) have you ever been subject to a Medical Defence Organisation Adverse Member Procedure? ☐ Yes ☐ No

e) have you ever had your membership of a Medical Defence Organisation or similar refused, cancelled or non-renewed? ☐ Yes ☐ No

f) has any insurer ever declined to insured you, imposed special terms, cancelled or declined to renew your insurance? ☐ Yes ☐ No

g) have you ever been convicted of any criminal offence or received a formal caution not spent under the Rehabilitation of Offenders Act 1974? ☐ Yes ☐ No

If the answer to any of the above is 'yes' then please attach full details including an explanation of the background of events, all relevant dates, the status of the claims or circumstances, the maximum amount involved or claimed and any reserves or payments made.

SECTION 8: DECLARATION

I declare that:

- after full enquiry the answers to the questions contained in this application form, and any other information supplied by me, are substantially true, accurate and correct;
- I will inform underwriters before cover incepts of any change to the information supplied by me; and
- I understand that if any of the information contained in this application form or provided elsewhere is substantially untrue, inaccurate or incorrect, or I have not disclosed any other information that is material, the Policy may be avoided without any return of premium, the terms and conditions may change, a higher premium may become payable or we may reduce the amount of any claim payment.

Signed: _____ Full name: _____

Date: DD / MM / YY

Data Protection Act *– All personal information supplied by you will be treated in confidence by CFC Underwriting 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 CFC Underwriting Ltd or our agents or subcontractors.*

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ADDITIONAL INFORMATION: