Chubb Elite Medical Malpractice Insurance

Proposal Form - For Medical Establishments

CHUBB®

Important Notices to the Applicant

Statement pursuant to Section 25 (5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof) - You are to disclose in this Proposal Form fully and faithfully all facts which you know or ought to know, otherwise the policy issued hereunder may be void.

Your Duty of Disclosure
Before you enter into a contract of general insurance with an Insurer, you have a duty to disclose to the Insurer 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 Insurer;
- that is of common knowledge;
- that your Insurer knows or, in the ordinary course of its business, ought to know;
- as to which compliance with your duty is waived by the Insurer.

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 Insurer may be entitled to void the contract from its beginning.

If your non-disclosure is fraudulent, the Insurer may also have the option of avoiding the contract from its beginning, to retain any premium that you have paid for this contract of insurance.

Change of Risk or Circumstances
You should advise the Insurer as soon as practicable of any change to your normal business as disclosed in the proposal, such as changes in location, acquisitions and new overseas activities.

Subrogation
Where you have agreed with another person or company, who would otherwise be liable to compensate you for any loss or damage which is covered by the policy, that you will not seek to recover such loss or damage from that person, the Insurer will not cover you, to the extent permitted by law, for such loss or damage.

Instructions to the Applicant

A. Before completing this section, please read the important notices starting on page 1.
B. This proposal must be completed, signed and dated by a Principal, Partner or Director.
C. You must answer all the questions in this form. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
D. If you are a new practice, use the projected figures from your business plan.
E. If you have any questions concerning this proposal, please contact your insurance broker or adviser to discuss.

Application for Insurance Cover

Period of Insurance From DD / MM / YYYY To DD / MM / YYYY

Limit of Insurance Required Option 1 SGD _____ Option 2 SGD _____

Excess / Deductible Requested Option 1 SGD _____ Option 2 SGD _____

Type of Insurance Requested ☐ Insurance ☐ Reinsurance

Are you requesting cover for Fraud & Dishonesty? ☐ Yes ☐ No

Are you requesting cover for Principals' Previous Business? ☐ Yes ☐ No

1. Details of Applicant

1.1. Names and Company Registration Numbers of all practice entities applying to be covered under this insurance (Referred to as "you" or "your" in the rest of this form).

1.2. Has your name ever been changed, or have you purchased or merged with any other practice or business? ☐ Yes ☐ No

If **Yes**, please attach details.

1.3. Please list your principal address.

_____ Postal Code _____

1.4. Please list the address(es) of your branch offices or other locations (if applicable).

1.5. Please list your website address.

_____

1.6. When was your practice entity established? DD / MM / YYYY

1.7. Please indicate:

Type of Facility

☐ Private Hospital ☐ Public Hospital ☐ Hospital - Other ☐ Clinic ☐ Group Practice ☐ Nursing Home
☐ Retirement Village ☐ Rehabilitation Centre ☐ Hospice ☐ Laboratory ☐ Pharmacy

Nature of Practice Entity

☐ Joint Venture ☐ For profit ☐ Not for Profit ☐ Limited Liability Company ☐ Limited Partnership

1.8. Please indicate the number of personnel applicable below.

Classification	P/T	F/T	Classification	P/T	F/T
Principals, partners or directors			X-ray technicians		
Doctors (including locum doctors)			Physiotherapists		
Surgeons			Midwives		
Interns			Healthcare assistant / health workers		
Registered nurses			Other registered professionals		
Enrolled nurses			Other skilled & technical employees		
Pharmacists			Non-technical administrative staff		
Laboratory technicians			Other staff (please specify)		
Dentists			**Total**		

1.9. Please list the qualifications of your Principals, Partners, Directors or other key professional personnel.

Name	Qualifications	Year Qualified	Years as Principal. Partner or Director	
			This Practice	Previous Practice

1.10. If there is only a sole Principal, what arrangements do you have in place to ensure business continuity when that Principal is travelling, on leave, ill or away from the office?

2. Details of Business

2.1 Which professional societies & associations are you, your Principals, Partners or Directors members of?

2.2 Is your practice entity duly licensed to practice at the address(es) specified in Questions 1.3 and 1.4? ☐Yes ☐No

2.3 Do you ensure that all doctors providing medical services for or using the facilities of your practice entity are members of a Medical Defense Union or Medical Protection Society or otherwise carry their own medical malpractice insurance covers? ☐Yes ☐No

If **No**, are you requesting coverage for these doctors as part of your application? ☐Yes ☐No

2.4 Are you ISO 9001 certified? ☐Yes ☐No

If **Yes**, when was this achieved and for which activities?

2.5 What is the total number of beds? _____

2.6 What is the average annual occupancy rate? _____

2.7 What is the total number of bassinets? _____

2.8 What is the average annual occupancy rate? _____

2.9 What is the total number of patients annually? (i) Outpatients: _____ (ii) Inpatients: _____

2.10 Do you have an:

(i) Intensive care unit (ICU)? ☐Yes ☐No

(ii) Accident & emergency (A&E) department? ☐Yes ☐No

(iii) Outpatients department? ☐Yes ☐No

(iv) Medical teaching facility? ☐Yes ☐No

(v) Pathology facility? ☐Yes ☐No

(vi) Blood banking facility? ☐Yes ☐No

Helipad Liability

2.11 Do you own or operate a heliport or helipad? ☐Yes ☐No

If **No**, please disregard the remaining questions in this section.

a) Number of annual landings _____

b) Where are the heliports / helipads located?

☐Lawn ☐Roof ☐Carpark ☐Other (Please specify _____)

c) Is the helicopter landing pad approved by the governing aviation authority? ☐Yes ☐No

d) Is the medical team comprised of certified and experienced retrieval medicine physicians and registered nurses with critical care and emergency nursing experience? ☐Yes ☐No

2.12 What percentage of your activities are represented by each of the following types of professional healthcare services:

Type of Services	%	Type of Services	%
Audiology		Oncology	
Aged Care / Assisted Living		Ophthalmology (including LASIK & laser)	
Cardiology		Paediatrics	
Communicable Disease / Tubercular		Pathology	
Dentistry		Physiotherapy	
Dermatology		Plastic surgery (elective cosmetic)	
Drug / alcohol dependency		Plastic surgery (reconstructive)	
Ear / Nose / Throat		Podiatry	
Elective Termination		Psychiatric	
Gastroenterology		Radiography / medical imaging	
General Practice / General Medicine		Rehabilitation	
Gynaecological		Surgical	
Invitro Fertilisation (IVF)		Traditional medicine	
Obstetrics / maternity		Other (please specify)	
		Total	100 %

2.13 Do you engage in any other professional healthcare services or business activities other than what is described in this section? If **Yes**, please attach details of the type of work and the fee income from these other activities. ☐Yes ☐No

2.14 Are you or any of your Principals, Partners or Directors connected or associated with any other practice or business? ☐Yes ☐No

If **Yes**, please attach details.

3. Details of Business

3.1 When does your Financial Year end? DD / MM

3.2 What is your total turnover or fee income for the:

	Year	Singapore	Total
Coming year (est.)		SGD	SGD
Current year (est.)		SGD	SGD
Past year		SGD	SGD

3.3 Please indicate your patient demographic.

Singapore (%)	Other Asia (%)	Australia / NZ (%)	Europe (%)	USA / Canada (%)	Others (%)	Total
						100 %

3.4 Please list the foreign countries you provide services in and the number of staff located in each.

Country	Number of Staff	Country	Number of Staff

4. Risk Management

4.1. 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 in the country where you practice? ☐Yes ☐No

4.2. Do you maintain accurate and descriptive records of all medical services rendered, and equipment used in procedure? ☐Yes ☐No

4.3. Do you have facilities for sterilisation of instruments in accordance with relevant guidelines/standards applying to your industry? ☐Yes ☐No

4.4. Do you have and follow documented risk management and quality control procedures? ☐Yes ☐No

4.5. Are these risk management and quality control procedures regularly reviewed and updated to the appropriate standards applying to your industry? ☐Yes ☐No

4.6 Do you have standard procedures for the reporting of medical incidents? ☐Yes ☐No

5. Insurance History

5.1. Do you currently have medical malpractice? ☐Yes ☐No

If **Yes**, please provide details.

Period of Insurance	Insurer	Policy Limit (SGD)	Excess (SGD)	Retroactive Date

5.2. Have you ever had any application for medical malpractice insurance refused, or had any medical malpractice insurance coverage rescinded or cancelled? ☐Yes ☐No

If **Yes**, please provide brief details below or on a separate sheet, noting the Section number.

6. Cyber and Privacy Infringement Liability

(Only complete this section if you request cover for Cyber and Privacy Infringement Liability Extension)

6.1 Do you have a formal policy to segment sensitive data? ☐Yes ☐No

6.2 Do you encrypt sensitive information including medical records and personal data anywhere that it is stored, transmitted and/or on mobile devices? ☐Yes ☐No

6.3 Do you currently carry or are you in the process of applying for D&O or Cyber/Privacy Coverage? ☐Yes ☐No

6.4 Do you have a person dedicated for Information Security? ☐Yes ☐No

6.5 Do you have a Written Information Security Program (WISP)? ☐Yes ☐No

6.6 Have you taken all necessary steps to ensure compliance with the Personal Data Protection Act 2012 of Singapore (Chapter 26 of 2012) and/or any similar law or regulation in any other jurisdiction which governs the collection, use, ☐Yes ☐No

processing, handling, storage, disclosure or transfer of personal/sensitive information?

6.7 Have you undergone an Information Security Audit? ☐Yes ☐No

If **Yes**, when was the date? DD / MM / YYYY

If **Yes**, was the result satisfactory? Please describe:

7. Claims Experience

7.1. Have any claims ever been made, or lawsuits been brought against you, your predecessors in business, or any current or former Principals, Partners, Directors, employees, or any other person or entity applying to be insured under this proposed contract of insurance? ☐Yes ☐No

7.2. Are any of the Principals, Partners, Directors or employees aware, after inquiry, and as of the date of signing this application, of any errors, omissions, offences, circumstances or allegations which might result in a claim being made against you or any person or entity applying to be insured under this proposed contract of insurance? ☐Yes ☐No

7.3. Have you, your predecessors in business, or any current or former Principals, Partners, Directors, or employees ever been the subject of disciplinary action or investigation by any authority or regulator or professional body? ☐Yes ☐No

If you had answered **Yes** to any of the questions in this section, please provide full details and the status of each claim, lawsuit, allegation or matter, including:

- the date of the claim, suit or allegation
- the date you notified your previous insurers
- the name of the claimant(s) and the establishment(s)
- the allegations made against you
- the amount claimed by the claimant(s)
- whether the status is outstanding or finalised
- the amounts paid for claims and defence costs to date

8. Additional Information to Send with Your Application

Attach a copy of the following:	Included?	
Corporate profile, brochures, pamphlets, or other marketing material describing your operations and services	☐ Yes	☐ No
Standard contracts or service agreements with clients or patients	☐ Yes	☐ No
Resumes or CVs of all your Principals, Partners or Directors	☐ Yes	☐ No
For new businesses only, your business plan with projections of business	☐ Yes	☐ No

Declaration

We have read and understood the Important Notices contained in this application.

We agree that this proposal, together with any other information or documents supplied with this proposal, will form the basis of any contract of insurance.

We acknowledge that if this application is accepted, the contract of insurance will be subject to the terms and conditions as set out in the policy wording as issued or as otherwise specifically varied in writing by the insurer.

We declare, after inquiry of all relevant persons within our organisation, that the statements, particulars and information contained in this application and in any documents accompanying this application are true and correct in every detail and that no other material facts have been misstated, suppressed or omitted.

We undertake to inform the insurer of any material alteration to those facts before completion of the contract of insurance.

Commission Disclosure

The Proposer understands, acknowledges and agrees that, as a result of the applicant purchasing and taking up the policy to be issued by Chubb, Chubb will pay the authorised insurance broker commission during the continuance of the policy including renewals, for arranging the said policy.

This form must be reviewed, signed and dated by a duly authorised Principal, Partner or Director. The authorised person who signs on behalf of the Proposer further confirms to Chubb that he or she is authorised to do so.

Personal Information Collection Statement

Chubb Insurance Singapore Limited ("Chubb") is committed to protecting your personal data. Chubb collects, uses, discloses and retains your personal data in accordance with the Personal Data Protection Act 2012 and our own policies and procedures. Our Personal Data Protection Policy is available upon request. Chubb collects your personal data (which may include health information) when you apply for, change or renew an insurance policy with us, or when we process a claim. We collect your personal data to assess your application for insurance, to provide you with competitive insurance products and services and administer them, and to handle any claim that may be made under a policy. If you do not provide us with your personal data, then we may not be able to provide you with insurance products or services or respond to a claim.

We may disclose the personal data we collect to third parties for and in connection with such purposes, including contractors and contracted service providers engaged by us to deliver our services or carry out certain business activities on our behalf (such as actuaries, loss adjusters, claims investigators, claims handlers, third party administrators, call centres and professional advisors, including doctors and other medical service providers), other companies within the Chubb Group, other insurers, our reinsurers, and government agencies (where we are required to by law). These third parties may be located outside of Singapore.

You consent to us using and disclosing your personal data as set out above. This consent remains valid until you alter or revoke it by providing written notice to Chubb's Data Protection Officer ("DPO") (contact details provided below). If you withdraw your consent, then we may not be able to provide you with insurance products or services or respond to a claim.

From time to time, we may use your personal data to send you offers or information regarding our products and services that may be of interest to you. If you do not wish to receive such information, please provide written notice to Chubb's DPO.

If you would like to obtain a copy of Chubb's Personal Data Protection Policy, access a copy of your personal data, correct or update your personal data, or have a complaint or want more information about how Chubb manages your personal data, please contact Chubb's DPO at:

Chubb Data Protection Officer
Chubb Insurance Singapore Limited
138 Market Street
#11-01 CapitaGreen
Singapore 048946
E dpo.sg@chubb.com

Signed, Principal / Partner / Director

Name of Signatory

Date

Contact Us

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