

Private Aesthetic &
Cosmetic Professional
Indemnity Insurance
Application Form



servca



Servca
One Aldgate
4th Floor London
EC3N 1RE

T. +44(0)207 0143205
E. insurance@servca.com
W. www.servca.com

Private Aesthetic & Cosmetic Professional Indemnity Insurance

Please read and understand the following notes before you complete this form.

Claims Made

This insurance is provided on a 'Claims Made' basis. This means that insurers will only consider claims that are notified to them during the policy period and which occurred after a specific date agreed by insurers (stated on your Certificate of Insurance as Retro-Active Date.)

Training Certificates

In the event of a claim, proof of training maybe required. Treatments not supported by relevant training certificates may not be accepted for Insurance. We reserve the right to check the validity of any certificates/training with the specific training organisation. If you are in doubt please do not hesitate to let us know.

Claims

Any claims/incidents reported in the last 10 years must be declared within the proposal. Failure to provide correct information would be deemed a material fact and could jeopardise your policy in the event of a claim. If you have uncertainties please do not hesitate to check prior to the acceptance of this proposal.

Cancellation

These policies are written on a non-cancellation basis and do not contain a policy-holder cancellation clause. Cancellation is subject to acceptance from Insurers. Please note that your underwriters DO have an option to cancel the policy should you fail to disclose all information required by them.

Controls and Protocols

It is a condition of this insurance that you provide facilities for the sterilisation of instruments in accordance with current guidelines, employ effective cross-infection control methods and retain patient records for a minimum period of 10 years.

Acceptance of Your Proposal

Upon acceptance of the underwriter's terms and payment of the premium, all information provided by you together with supporting documentation will be deemed to be incorporated into the contract between you and the insurer. You should keep copies of this proposal and supporting documentation for your own records.

Material Facts

It is the duty of the proposer to disclose all material facts to the underwriter. Where information is omitted the insurer may avoid their obligation under the policy.

A material fact shall be deemed to be one that would be likely to influence an underwriter's judgment and acceptance of your proposal. If you are in any doubt as to what you consider to be disclosed, you should inform us of this at the time of completing this proposal.

Material Changes

Any 'material change' must be disclosed to Insurers at your earliest opportunity.

A 'material change' is any information which may alter the judgment of an Underwriter that has no previously been disclosed as a material fact.

If you are in any doubt as to what you consider to be disclosed, you should inform us of this at the time of completing this proposal.

Presentation

This presentation must be completed in ink by the proposed individual. All questions must be answered. Any additional sheets can be included within the proposal.

THE SIGNING OF THIS PROPOSAL DOES NOT BIND THE PROPOSER OR THE UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE

This application form should only be completed by practitioners who practice in their own capacity. If cover is required for a company or partnership, or where you require one or more of your staff to be protected by medical malpractice insurance, you should complete a CORPORATE proposal form.

Please tick this box to confirm you understand all of the above



About Us

1. Full Name of Proposer
2. Trading Name (if different from the above)
3. How long have you been trading?
4. Have you ever engaged in a similar activity under a different name?

If YES please give full details

5. Correspondence address

Postcode:

Country:

Tel No:

Mobile No:

Email:

6. Practice/Trading address (if different from above)

Postcode:

Country:

Tel No:

Mobile No:

Email:

If cover is required for more than one location, please attach a list of all addresses

About Your Qualifications

7a. In what capacity are you qualified or licensed to practice? (Please tick)

Nurse

Doctor

Surgeon

Dentist

Other (Please give details)

7b. Please specify your qualification

7c. If other please state

8a. Please state your GMC/GDC/NMC membership number (if applicable)

8b. Has membership or registration with this organisation ever been suspended, withdrawn, amended, declined or had special conditions attached?

If YES please provide full details

8c. Are you a member of any specialist associations or regulatory bodies or organisations?

If Yes, please give full details

About Your Income

9. What is your total gross annual turnover from the performance of all treatments for which this proposal relates? (If this is a new business please state the estimated income)*

£

10. How many patients/customers do you anticipate to treat in the next 12 months?

11. Are you VAT Registered?

***Please note: turnover relates to total money generated from the treatments you require cover for, not personal income**

General Questions

- 12.** Do you, or any person to which this proposal relates, suffer from any disability, transmittable disease (Hepatitis, HIV etc) or other impediment which may affect the performance of his or her professional duties?

If Yes, please give full details

- 13.** Have you, or any person to which this proposal relates, been the subject of a criminal offence (other than minor motoring convictions), professional disciplinary proceedings or enquiries?

If Yes, please give full details

- 14.** Do you perform any activities outside of the UK, Channel Islands or Isle of Man?

If Yes, please give full details

- 15a.** Do you perform any activities outside of the UK, Channel Islands or Isle of Man?

- 15b.** If YES please state your renewal date

DD/MM/YYYY

- 16.** Are you registered with the Care Quality Commission?

- 17.** Are you registered with your local authority?

- 18a.** Do you undertake any Clinical Trials?

- 18b.** If YES please give full details

19a. Do you provide Aesthetic Training?

19b. If YES please give full details

20. Has all qualifications/training been obtained in the UK?

Previous Insurance and Claims Experience

21. Have you ever been insured for Medical Malpractice Insurance/Medical Indemnity Insurance?

If YES please state

a. The name of the Underwriter/
Indemnity Provider

b. The insurance periods DD/MM/YYYY From To

c. The limit of liability provided £

d. The excess/deductable applied £

22. Has any application for this type of insurance ever been

a. declined

b. cancelled

c. had special terms imposed

d. have you ever been subject to any
disciplinary action

If YES to any of the answers above, please give full details

23. Have you ever had a claim for medical malpractice or public liability made against you in the last 10 years?

If YES please provide full details below

	Date of Incident	Date of Claim	Amount Claimed	Amount Paid (indemnity)	Amount Outstanding	Details including nature of allegations and the details of the claimant
1						
2						
3						
4						
5						

24. Are you aware of any other circumstance/complaint which may give rise to a claim being made against you?*

If YES please provide full details below

	Date of Incident	Details of Incident/Complaint
1		
2		
3		
4		
5		

**If there is insufficient space to providers answers, additional information can be provided in the additional information section on the last page of this form.*

25a. Have all of the above in questions 23 and 24 been notified to your previous underwriter?

25b. Have all of the above been accepted by your previous underwriter?

Additional Information

Declaration

I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal, and supplementary attachments/addenda, 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 practical. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of this Proposal may result in the Underwriters refusing to provide Indemnity 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.

SIGNATURE

NAME OF PROPOSER

DATE

DD/MM/YYYY

Servca Healthcare and Servca London Markets are trading names of Servca Ltd, who are authorised and regulated by the Financial Conduct Authority under FRN 596006. Registered in England & Wales under company number 7727494.

