Lonsdale

COSMETIC INSURANCE

MEDICAL PRACTITIONERS APPLICATION FORM

Claims Made Basis

Our policies are written on a claims made basis. This means that in order for your policy cover to apply, all claims and any fact, situation, incident or circumstance that may result in a claim, must be reported to the insurers during the same policy period in which they first come to light. Retroactive, Extended Reporting Periods and Run Off Cover are available.

Material Facts & Material Changes

It is understood that you have provided complete and accurate information to Insurers and that you have complied with your legal duty to disclose, before inception of the insurance contract, all material matters relating to the risk (i.e. all information which would influence the judgement of a prudent Insurer in determining whether to underwrite the risk and if so, upon what terms and at what premium). If all such information has not been disclosed, Insurers have the right to avoid the contract from its commencement, which may lead to claims not being met. If you believe that you may not have complied with this duty or are unsure, you should contact us immediately.

Changes affecting either material facts or your business activities must be immediately notified to us. It is your responsibility to advise your insurers immediately of any changes, which may affect your insurance risks, and/or which vary the details provided on the original proposal forms/statement of facts/presentations. Failure to do so could invalidate your cover.

Training

Cover would be subject to the completion of the relevant training course for the relevant treatments you require cover for. Failure to do so could jeopardise your policy in the event of a claim.

You can e-mail completed forms to: medical.malpractice@lonsdaleib.com or you can send completed forms to: Lonsdale, 148 Leadenhall Street, London, EC3V 4QT

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1. General Details

Full Name	
Company / Trading Name (if applicable)	
Contact Number(s)	
E-Mail Address	
Correspondence Address	
Trading Address	
Length of current business	
Previous Company / Trading Name (if applicable)	

2. Practitioner Details

GMC Membership Number		
Are you on the Specialist Register for Plastic and Reconstructive Surgery?	YES ☐	NO ☐
Are registered with any other governing body / organisation / association?	YES ☐	NO ☐
If yes, please specify:		

Is cover required for any other practitioners under this proposal	YES ☐	NO ☐

If yes please complete the details below

Name, Position and Professional Qualification	Professional / Governing Body	Membership Number	Employed / Self-Employed	Is cover required under this policy	
				YES ☐	NO ☐
				YES ☐	NO ☐
				YES ☐	NO ☐
				YES ☐	NO ☐
				YES ☐	NO ☐
				YES ☐	NO ☐

Do you, or anyone stated under this proposal, suffer from any disability, disease, impediment or any other condition which could affect your/their performance?	YES ☐	NO ☐
If yes please provide full details:		

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Have you, or anyone stated on the proposal, been convicted of or charged with any offence, other than a motoring offence or conviction spent under the Rehabilitation of Offenders Act 1974?	YES ☐	NO ☐
If yes, please specify:		

Have you ever been declared bankrupt or become insolvent or made any voluntary arrangement with creditors or been subject to enforcement of a judgment debt either in a personal capacity or as a business?	YES ☐	NO ☐
If yes, please specify:		

3. Activities

What is your estimated turnover for the next 12 months for which this policy relates excluding the sale of goods	£
What was your turnover for the last 12 months for which this policy relates excluding the sale of goods, if applicable	£
Estimated turnover in relation to the sale of goods	£
What is your estimated treatment numbers for the next 12 months to which this policy relates	

Do you undertake any clinical trials?	YES ☐	NO ☐
If yes, please specify:		

Do you undertake any Medico Legal work?	YES ☐	NO ☐
If yes, please specify:		

Do you provide prescribing services for other practitioners?	YES ☐	NO ☐
If yes, please specify:		

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4. Claims & Incidents

Are you aware of any claims or incidents made in the last 10 years?	YES ☐	NO ☐

If yes please complete the details below

Incident Date	Procedure Type	Practitioner	Claimant Name	Value of claim	Paid or reserved?	Details

Are you aware after reasonable enquiry of any shortcoming in your work which is likely to lead to a claim against you?	YES ☐	NO ☐
If yes, please specify:		

Please confirm that all records, to date and in the future will be maintained for at least 10 years?	YES ☐	NO ☐
Are photographs taken pre and post first treatments?	YES ☐	NO ☐

5. Previous Insurance

Have you previously been insured for Medical Malpractice Insurance?		YES ☐	NO ☐
Insurer Name			
Limit of Indemnity Provided			
Period of Insurance			
Policy Basis		Claims Made ☐	Claims Occurred ☐

Do you require retroactive cover?	YES ☐	NO ☐
If so, from which date?		

Has any insurer ever cancelled your policy, declined/refused to renew, or only accepted the risk at special terms for Insurance of this nature?	YES ☐	NO ☐
If yes, please specify:		

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6. Treatments

Which treatments do you provide?	YES	NO	Name of practitioner providing treatment	Percentage of practice
Botox				
Dermal Fillers				
Chemical Peels				
PDO Threads				
Silhouette Soft				
P & O Shot				
Laser Treatments				
Laser Lipolysis/Vaser				
Radio Frequency				
Sclerotherapy				
Rhinoplasty				
Blepharoplasty				
Breast Augmentation				
Breast Enlargement				
Breast Reduction				
Penoplasty				
Vaginoplasty				
Liposuction				
Cheek Implants				
Chin Implants				
Brow Lift				
Neck Lift				
Facelift				
Abdominoplasty				
Mole/Skin Tag/Wart/Cyst Removal				
Thigh Lift				
Mastopexy				
Gynaecomastia				
Labiaplasty				
Otoplasty				
Brachioplasty				
Hand Surgery				
Other (please specify)				

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Which date is cover required from?

I/We declare that (a) this proposal acceptance form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of my/our proposal for insurance have been disclosed.

I/We undertake to inform you before any contract of insurance is concluded, if there is any material change to the information already provided or any new fact or matter arises which may be relevant to the consideration of my/our proposal for insurance.

I/We understand that non-disclosure or misrepresentation of a material fact or matter will entitle the insurer to avoid this insurance.

I/We agree that this proposal acceptance form and all other information which is provided are incorporated into and form the basis of any contract of insurance.

I/We confirm that, after reasonable enquiry, there are no claims against me/us nor any circumstance that may give rise to a claim or a loss.

Name	
Position	
Date	
E-Mail	
Signature	

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LETTER OF AUTHORITY FOR REPORTING

Dear Sir/Madam

This letter is to confirm that I have authorised Lonsdale Insurance Brokers, 148 Leadenhall Street, London, EC3V 4QT as my/our exclusive Insurance Broker.

The appointment of Lonsdale Insurance Brokers rescinds all previous appointments and the authority contained herein shall remain in force until cancelled in writing.

Thanks for your cooperation

Name: ……

Date: ……

Signature:……