

## IMPORTANT INFORMATION – PLEASE READ

This application is for a claims made policy underwritten by various Lloyds Syndicates.

This application form must be completed clearly using blue or black ink.

It is the duty of the applicant to disclose all material facts. A material fact is deemed to be one that would be likely to influence an underwriter's judgement and acceptance of the risk. Any misrepresentation of material fact may result in underwriters avoiding a claim or declaring your policy void without refund.

Once completed, please return this application to Paragon International Insurance Brokers.

Any changes to any of the information contained in the application form must be advised to your insurance broker as soon as practicable.

If you have any additional information which may be relevant to your application, please provide in Section 5, providing reference to the appropriate question, or attach the relevant documentation.

**THE SIGNING OF THIS APPLICATION FORM DOES NOT BIND THE APPLICANT, OR UNDERWRITERS, TO COMPLETE A CONTRACT OF INSURANCE.**

### Section 1 – Basic Information

|                                     |   |        |                          |
|-------------------------------------|---|--------|--------------------------|
| Title                               | <input type="text"/>                        |        |                          |
| Male                                | <input type="checkbox"/>                    | Female | <input type="checkbox"/> |
| Surname                             | <input type="text"/>                        |        |                          |
| Forename(s)                         | <input type="text"/>                        |        |                          |
| Date of Birth                       | <input type="text"/>                        |        |                          |
| Postal Address                      | <input type="text"/>                        |        |                          |
| Postal Code                         | <input type="text"/>                        |        |                          |
| E-mail                              | <input type="text"/>                        |        |                          |
| Contact Tel.:                       | <input type="text"/>                        |        |                          |
| When would you like cover to begin? | <input type="text" value="dd / mm / yyyy"/> |        |                          |

### Section 2 – Professional History

|  |                                  |                          |    |                          |
|--|----------------------------------|--------------------------|----|--------------------------|
| Are you registered with the appropriate medical council? | Yes                              | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Are you a member of the MPS?                             | Yes                              | <input type="checkbox"/> | No | <input type="checkbox"/> |
| What is your current membership subscription?            | <input type="text" value="XCD"/> |                          |    |                          |

### Section 2 – Professional History (continued)

If you are not a member of the MPS, please answer the following.

|   |   |
|---|---|
| Who is your current insurer?              | <input type="text"/>                        |
| What is the Retroactive Date?             | <input type="text" value="dd / mm / yyyy"/> |
| What is the expiring premium?             | <input type="text" value="XCD"/>            |
| What is your expiring limit of indemnity? | <input type="text" value="XCD"/>            |
| What is your expiring excess?             | <input type="text" value="XCD"/>            |

### Section 3 – Practice Profile

In which area of medicine/dentistry do you practice?

Have any claims, or circumstances that may lead to a claim, for compensation been made against you?

Yes  No

If Yes, please give full details using the additional space on the back page or alternatively please provide prior insurer loss run or case history.

### Section 3 – Practice Profile (continued)

Only with respect to your private practice, please can you confirm the following:

No. of days worked per month last year

Estimated no. of days worked per month for the coming year

No. of Consultations per month

No. of Non-Surgical Procedures per month

No. of Minor Procedures per month

No. of Major Procedures per month

### Section 4 – Declaration

I declare and warrant that after enquiry all statements and particulars contained in this Application are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Application and should the above particulars alter in any way, I will advise my insurance broker as soon as practicable. I understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Application may result in the refusal to provide indemnity or voiding the policy in every respect. I hereby accept that this Declaration shall be the basis of the contract between both parties if entered into. By signing this document, I authorise my insurance broker and Paragon International Insurance Brokers Ltd to release information, if applicable.

Name of Applicant

Applicant's Signature

Date of Signature

### Section 5 – Additional Information