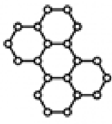

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MCI

Infectious Disease Liability Application Form

Healthcare

Section 1 - Company Details

Name of Organisation:			
Trading name (if different):			
Contact tel:		Contact email:	
Date established:		Web address:	

Principal address:
Registered address (if different):
Please attach a list of any additional locations

Role:	
	Owner
	Operator
	Facility manager
	Specific Service provider, *e.g. Cleaning, Home care*

Tax status:	For profit	Not for profit	Public	Government Entity

List of professional bodies/associations/regulatory bodies with whom you hold a license /membership	
Have you ever had any disputes/conditions/orders placed on you related to Cross-Infection/Infectious disease by a regulatory body or recognised health authority following an inspection?	
if "Yes" please provide details:	
Have those who own or operate the operations, previously had experience in the healthcare market?	
If '*Yes*', have they had any investigations in their operations or bankruptcies/liquidations?	

Section 2 - Exposure Details

	Past Financial Year	Current Financial Year	Next Financial Year
Financial			
Gross revenue			
Profit/Loss			
Beds			
Admitted			
Day-care			
Total			
% Occupancy	%	%	%

Professional Services

General Hospital	Diagnostic Imaging Facilities	University Hospital	Acute Hospital
Community Hospital	Clinic	Walk in centre	Primary Care Clinics
Aesthetic Treatment Clinics	Diagnostic Imaging Facilities	Hospices	Outpatient Surgery Centres
Ambulance Services	Drug Testing Centres	Industrial / Occupational Health	Primary Care Clinics
Assisted living	Emergency / Urgent Care Centres	IVF/ Assisted Conception	Rehabilitation Centres
Clinical Research Establishments	First Aid / Paramedic Group	Medical Employment Agencies	Residential Care
Complementary Medical Facilities	GP surgery	Medical Repatriation / Air Ambulance	Specialty Care Clinics
Dental clinic	Home Health Services	Home Care Services	
Other (please specify)			

Section 3 - Staff (Staffing questions to apply to employed, non-employed, students and volunteers unless otherwise stated)

Domiciliary		Physicians		Students	
Nurses		Auxiliary care		Other, *Please list*	
Clerical		Volunteers			

Are all staff vaccinated against Hepatitis B and is this monitored appropriately?	
Do staff receive guidance on working if showing symptoms of an infectious illness?	
(If yes please outline)	
Do you require that all medical staff are registered and/or licensed with the relevant regulatory body?	
Do you require all non-employed medical staff to carry their own medical insurance?	

Section 4 - Risk Management / Infection Control

Question	
Are all minimum PPE requirements met, as set by your relevant regulating health authority (If applicable)?	
Do you have a PPE supplier which is accredited to minimum standards/ guidelines set by your relevant regulating health authority?	
Is there an infection control induction for all staff covering:	
a) prevention of outbreaks and cross infection	
b) management of active outbreaks	
c) clean-up following potential transmission/exposures	
d) Do all staff have a high-level awareness of health authority guidelines in respect of infectious disease control?	
Does training include use (donning/doffing) of PPE prior to use?	
Do you advise visitors to the premises when to use PPE?	

Policy

Question	
Do you have detailed infection control policies in place?	
Do you have a named individual(s) responsible for coordinating responses and reviewing these policies? *If "Yes": Please detail this Individual's Certifications/ Experience in Infection control*	
Are Cleaning and Sanitisation procedures in place (to industry standard)?	
Do you have an outbreak response plan?	
Are all medical staff trained in what to do in the event of an infectious disease outbreak?	
How often is this training reviewed?	
Do you have a written procedure for the documentation and investigation of events resulting in infectious disease adverse outcomes or near misses?	
In the event of an outbreak, or possible outbreak, is there a protocol for informing contacts of potential exposure?	
Do you have policies and procedures for isolating infectious individuals?	

General

Question	
Do you have a complaints system and nominated complaints manager?	
Do you have a reliable method for recording and passing on messages regarding patient status or care?	
Are you aware of any complaints or claims that have ever been brought and/or threatened against you, and/or any circumstances which could lead to a complaint and/or claim against you? *If you have answered "Yes" please provide full details below or use the Outbreak history tracker template.*	

Screening / Testing / Vaccination

Do you have policies in place for the screening of staff and patients for Covid-19? *If no, under what circumstances are they tested (if any)?*	
Do you require Covid-Positive (or suspected Covid-Positive) staff to stay home until recovered or no-longer infectious?	

Section 5 - Infectious Disease Outbreak History

Are you aware of any Infectious disease outbreaks that occurred under your responsibility which resulted in injury/death of one or more person(s)?	

Please provide details of all recorded infectious disease outbreaks experienced at Insured Locations within the last 5 years, including non-COVID19:

Infecting organism/ disease:			
Approx. date: M/Y - M/Y		Length of outbreak:	days
Location(s) impacted:			
Number of infected individuals:		Deaths:	
Were there :	Complaints made?		
	Request for medical records?		
	Requests for compensation?		
Were any new risk management procedures implemented following the outbreak:			
Please provide any additional narrative:			

Infecting organism/ disease:			
Approx. date: M/Y - M/Y		Length of outbreak:	days
Location(s) impacted:			
Number of infected individuals:		Deaths:	
Were there :	Complaints made?		
	Request for medical records?		
	Requests for compensation?		
Were any new risk management procedures implemented following the outbreak:			
Please provide any additional narrative:			

Section 8 - Declaration

I/We declare that after full investigation I/we are unaware of any claims and/or circumstances that could give rise to a claim, other than those already declared in the proposal

I/We declare that the statements and particulars contained in the proposal are true and that I/we have not mis-stated or suppressed any material facts.

I/We agree that this proposal together with any other information supplied by me/us shall form the basis of any contract of insurance effected thereon.

I/We undertake to inform Insurers of any material alteration to these facts occurring before completion of the contract of insurance. However, the duty to disclose material facts continues after the completion of the proposal form and throughout any period of insurance (and any extension thereto), upon which this proposal form was used as the basis of the contract of insurance.

Signing this proposal form does not bind the proposer to complete this insurance.

Signature of authorised Individual/Partner/Principal/Director: ______________________________

Date: ______________________________

Print Name: ______________________________

Position: ______________________________

Please provide details of all recorded infectious disease outbreaks experienced at Insured Locations within the last 5 years, including non-COVID19:

Infecting organism/ disease:			
Approx. date: M/Y - M/Y		Length of outbreak:	days
Location(s) impacted:			
Number of infected individuals:		Deaths:	
Were there :	Complaints made?		
	Request for medical records?		
	Requests for compensation?		
Were any new risk management procedures implemented following the outbreak:			
Please provide any additional narrative:			

Infecting organism/ disease:			
Approx. date: M/Y - M/Y		Length of outbreak:	days
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Were there :	Complaints made?		
	Request for medical records?		
	Requests for compensation?		
Were any new risk management procedures implemented following the outbreak:			
Please provide any additional narrative:			