

IMPORTANT INFORMATION – PLEASE READ

This Application Form, which is designed for General Practitioners on the Medical Council register in Ireland, must be signed by the Applicant. It is the duty of the Applicant to disclose all material facts. For the purpose of this Application Form, a material fact shall be deemed to be one that would be likely to influence the judgement of a prudent insurer in fixing the premium or determining whether to underwrite the risk. Each section of this Application Form must be completed in full. Incomplete or unsigned forms will not be accepted. Should there be insufficient room on any part of the Application Form to record all necessary details, please use the space provided in Section 5 with reference to the appropriate question.

An up to date copy of your CV must accompany the completed application form.

Failure to disclose full and accurate details may entitle Insurers to void your contract of insurance and will mean that you are not entitled to any benefits of, nor make any claims against, your policy.

It is the responsibility of the Applicant to notify any future change of address or any changes in their professional circumstances.

Once completed, please sign and date the Declaration in Section 6 and return it to::

Challenge Insurance Brokers Limited
Challenge House, 11 Burnell Square,
Mayne River Way, Malahide Road,
D17 VY04.

Email: insurance@challenge.ie
Tel: +353 1 8395942

Should you have any questions, please contact Challenge Insurance Brokers Limited on +353 1 8395942

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

Section 1 – Basic Details

1. Title	<input type="text"/>
3. Forename	<input type="text"/>
3. Surname	<input type="text"/>
4. Date of Birth	<input type="text"/>
5. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
6. Home Address (for all correspondence)	<input type="text"/>
7. Email Address	<input type="text"/>
8. Mobile No.	<input type="text"/>
9. Practice Website	<input type="text"/>
10. Practice Address	<input type="text"/>
11. Medical Council Registration No.	<input type="text"/> <small>Refer if no valid IMC registration</small>
12. IMC Registration Type	<input type="text"/>

Section 2 – Practice Profile

13. Please state the approximate percentage split between each of the following categories:

- i. Private Practice (Inc. Medical Card Scheme Income) % ii. Public Practice %

14. Please state the number of GP sessions undertaken per week, for which you require indemnity, performed in each of the following categories (A GP session is defined as clinic/period of 4 hours or less):

Split the total number of weekly sessions into the following categories (the total must match the number of sessions declared above)

- i. GP Practice based ii. Locum based iii. Out of Hours 8pm - 8am iv. Nursing Home
v. Other Please specify what "Other" sessions are

Total number of weekly sessions

Do you perform surgery other than incisions of boils and superficial abscesses, removal of ingrown toenails, cryotherapy or suturing of skin or superficial fascia?

Yes No

15. Please state the approximate percentage of your overall practice which involves patients under 16 years of age

%

16. Do you provide telemedicine consultations via video online or any similar platform?

Yes No

17. Do you, apart from house calls, provide services away from your surgery, e.g. at any factory, school, sports club etc.?

Yes No

18. Do you perform acupuncture?

Yes No

19. Do you provide occupational health service or advice?

Yes No

20. Do you perform vasectomies?

Yes No

21. a) Do you carry out home births?

Yes No

b) Do you provide ante or post natal services to patients opting for a home birth?

Yes No

22. Do you perform laser or cosmetic surgery and/or treatment including botox treatment?

Yes No

23. Do you practise and prescribe alternative medicine?

Yes No

24. Do you plan to cease all practice within the next 5 years?

Yes No

25. Is all work performed within the Republic of Ireland? (If No, Please provide additional details below)

Yes No

If you have answered Yes to any of the questions (14-25), please provide full details below

Section 3 – Professional History

26. What year did you begin private practice?

27. How many years have you been in practice as a General Practitioner?

28. In respect of your General Practice work, please provide details of such work in the past 3 years.

Name of Practice / Facility: From: To:

Name of Practice / Facility: From: To:

29. Please provide details of current insurance, if applicable.

i. Indemnity/Insurance provider ii. Year first joined

iii. Renewal/Expiry Date iv. Subscription in current year

30. Has your indemnity been continuous since qualification?

Yes No

31. Has any application for this type of insurance cover or membership of any defence body ever been declined, cancelled or required special terms?

Yes No

32. Have any claims for compensation been made against you for incidents or circumstances arising from public or private practice during the last 10 years? (If "Yes", please provide the relevant date with brief details using additional space in Section 5)

Yes No

33. Are you aware of any circumstances, from your public or private practice, which may give rise to a claim against you?

Yes No

34. Have all of the above circumstances been notified to your current indemnity provider or insurer?

Yes No

35. Have you ever been convicted of any criminal offence (other than minor driving offences), and/or subject to professional disciplinary proceedings by your employer and/or Regulatory or Medical Council Fitness to Practice procedures?

Yes No

Section 4 – Financial Information

36. What is your gross annual fee income from your private GP practice, excluding medico-legal:

i. for the past accounting year? €

€

ii. for the current accounting year? €

€

37. What is your gross annual income from medico-legal work only in your private practice:

i. for the past accounting year? €

€

ii. for the current accounting year? €

€

38. Do you provide your services or bill your patients via a Limited Company?

i. Please provide the company name and number

ii. Are you the only registered medical practitioner working for the company?

Yes

No

iii. Is the company set up solely for fiscal reasons?

Yes

No

iv. Does the company employ any staff (other than clerical/admin staff)?

Yes

No

v. If applicable, do you require cover for any of the staff included above?

Yes

No

Section 5 – Additional Information

Section 6 – Declaration and Disclosure

I declare and warrant that, after enquiry, all statements and declarations contained in the completed Application Form, together with any and all other information, statements and declarations made to Insurers, or their representatives, by or on behalf of the Insured, whether written or oral, are true and that no information whatsoever has been withheld which might increase the risk to Insurers or influence the acceptance of this Application Form. Should the above statements and declarations alter in any way, I will advise Challenge as soon as practicable. I understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of this Application Form 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 Challenge to release information to necessary third parties and give permission for Challenge to use my email address, as provided in Section 1, to send their quotations or correspondence.

Customer Signature

Print Name

Date