Chesterfield Group

MEDICAL MALPRACTICE APPLICATION FORM

Please provide as much information as possible in filling out this form. The more detail we have the better we are able to assess your risk and provide the most competitive terms. Please feel free to attach any documents or additional information that will assist us.
Please take care when completing this form, any misstatement may result in your insurance being cancelled and claims being declined in the future.

All information submitted will be treated as confidential and will only be used by Chesterfield Group in order to obtain Insurance terms.

SECTION 1		
Name:	Surname:	
Title:	Date of Birth:	
Home Address:	Work Address:	
Home Number:	Work Number:	Mobile Number:
Email address:		

SECTION 2
Please advise which area(s) of medicine you are qualified and licensed to practice:
Please provide your GMC Number:
How many years experience do you have in your surgical speciality?
Please provide the % breakdown of your private work between the following categories: Type of Practice — Employed % — Self-employed % Own private practice in a private hospital .... Own practice in NHS hospital ....
Gross Annual Income from Private Practice?
What % of your Income is generated from Consultations?
Do you plan to retire in the next 5 years? Yes ☐ No ☐
Do you undertake work on any high profile clients e.g. Sports personalities, celebrities etc. or professional sports clubs? Yes ☐ No ☐

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Are you aware of any complaints, claims or circumstances that have been brought or threatened against you, or any incident which could lead to such a complaint, claim or circumstance? If "yes" please provide details on an additional sheet. Yes ☐ No ☐	
Have you ever been subject to suspension from practice or any form of disciplinary action? If "yes" please provide details on an additional sheet. Yes ☐ No ☐	
Cover Start Date:	Cover End Date:
Existing Provider:	

Signature: ..... Date: .....

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