

PROPOSAL FORM / QUESTIONNAIRE

FOR A NO OBLIGATION QUOTATION FOR LOCUM / STAFF ABSENCE INSURANCE.

| | | |
|---|------------------|---------------------|
| DR. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms. <input type="checkbox"/> | Date | Office Use Only |
| Proposer (Normally this would be the Practice Manager) | | Position |
| Practice Name | | |
| Address | | |
| City | County | Postcode |
| Telephone | E-mail Address | |
| Existing Insurers (if any) | Existing Premium | Date Cover Required |

Persons to Be Insured (Please continue on a separate sheet if required)

| Title | Name | Date of Birth | Medical Practitioners | | Practice Nursing Staff | | Practice Administration Staff | |
|--|------|---------------|-----------------------|----------------------|------------------------|----------------------|-------------------------------|----------------------|
| | | | FTE Status | Weekly Benefit* £ | FTE Status | Weekly Benefit* £ | FTE Status | Weekly Benefit* £ |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Total FTE Status | | | | | | | | |
| Required No of Excess Weeks e.g. 0/2/4/8/13/26 | | | | | | | | |

* The Weekly Benefit Amount selected for each person must be appropriate, taking into account whether they are employed on a full or part time basis, the actual costs that may be incurred in hiring a temporary replacement, any reimbursement available from the NHS or local PCT or other source, or any amounts recoverable from any other policy of Insurance covering the same risks.

Absence History

| | 2007/2008 | | 2008/2009 | | 2009/2010 | |
|-------------------------------|------------------------------------|--------------------------|------------------------------------|--------------------------|------------------------------------|--------------------------|
| | Average number of Persons employed | Total No. of Days Absent | Average number of Persons employed | Total No. of Days Absent | Average number of Persons employed | Total No. of Days Absent |
| Medical Practitioners | | | | | | |
| Practice Nursing Staff | | | | | | |
| Practice Administration Staff | | | | | | |

Please give details overleaf of any single absence exceeding 2 working weeks duration

Please state if:

- 1. any person to be Insured is absent due to injury or illness at present Yes No
- 2. any person to be insured is likely to be absent in the future due to an existing injury or illness, including any planned surgery Yes No
- 3. any person to be insured has a medical history of stress, depression, anxiety or mental or emotional illnesses or disorders of any type Yes No
- 4. there is any person, permanently employed within the practice, which you have chosen NOT to insure under this Policy. Yes No

If you have answered yes to any of the above, please provide details below, giving number and category of person(s) employed, reason for absence/not being insured, and date(s).

Declaration

I/We understand/agree that

- 1. Signing this Proposal Form/Questionnaire does not obligate either party to complete the insurance
- 2. Should a contract of insurance be concluded this proposal form and the statements made herein shall be incorporated in and form part of the contract.
- 3. I/We are responsible for providing complete and accurate information when taking out my/our Policy and throughout the life of my/our Policy, that it is important that I/We ensure all statements made on my/our proposal form, over the telephone, on claim forms and other documents are full and accurate and that if I/We fail to disclose any material information (i.e. information that would influence MIAB in their the acceptance of the risk and/or terms applied) could invalidate my/our insurance cover and could mean that part or all of a claim may not be paid.

Data Protection Declaration

MIAB Will use the information you provide on this proposal form, together with other information for the purposes of underwriting and administering your policy, customer services and paying claims. Where you have answered any questions requiring the disclosure of sensitive personal data or provided additional information, including any medical information from any doctor both now and in the future, by signing this form, you also consent to MIAB using this information for the above purposes. You also consent to our transferring your information to other countries for the purposes outlined above. If we do make such a transfer we will put a contract in place to ensure your information is protected.

MIAB may contact you with details of additional schemes available to suit your insurance needs, including buildings contents and travel insurance. MIAB may also pass your information to carefully selected third party organizations. They or MIAB may contact you, by mail, e mail or telephone, to let you know about other goods or services which may be of interest to you. Please tick this box if you do not wish to receive such information.

Name

Position

Signature

Date