

### IMPORTANT INFORMATION – PLEASE READ

This Application Form, which is designed for consultants on the Irish Medical Council's specialist register, 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.

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      Email: [insurance@challenge.ie](mailto:insurance@challenge.ie)  
 Challenge House                              Tel: +353 1 8395942  
 Willie Nolan Road                              Fax: +353 1 8324254  
 Baldoyle  
 Dublin 13

#### Limits of Indemnity

Speciality	Limit of Indemnity per Claim	Aggregate Limit of Indemnity
Consultant Neurosurgeons and Orthopaedic Surgeons undertaking Spinal Surgery	€590,425	€1,771,275
All Other Specialties	€1,180,850	€6,500,000

The limits of indemnity you will be provided with will operate in cognisance of the Clinical Indemnity Scheme.

#### Policy Excess

The excess on this policy is NIL each and every claim

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 – Personal Details

Title	<input type="text"/>	Forename	<input type="text"/>	Surname	<input type="text"/>
Date of Birth	<input type="text" value="DD / MM / YY"/>	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
Home Address (for all correspondence)	<input type="text"/>			Email Address	<input type="text"/>
				Contact No.	<input type="text"/>
				Mobile No.	<input type="text"/>
Postcode	<input type="text"/>	Practice Website	<input type="text"/>		
Practice Addresses	<input type="text"/>			IMC Specialist Registration No.	<input type="text"/>
		Registration Type	Full <input type="checkbox"/>	Limited <input type="checkbox"/>	Provisional <input type="checkbox"/>
		In which country did you complete your fellowship?			
		<input type="text"/>			

## Section 2 – Practice Profile

1. Please indicate your specialty.

ANAESTHESIOLOGY	<input type="checkbox"/>	NEOPLASTIC DISEASES/ONCOLOGY SURGERY	<input type="checkbox"/>
BARIATRIC SURGERY	<input type="checkbox"/>	NEPHROLOGY	<input type="checkbox"/>
CARDIAC SURGERY	<input type="checkbox"/>	NEUROLOGY (NO SURGERY)	<input type="checkbox"/>
CARDIOVASCULAR DISEASE (NO SURGERY)	<input type="checkbox"/>	NEUROLOGY (SURGERY)	<input type="checkbox"/>
CARDIOVASCULAR DISEASE (SURGERY)	<input type="checkbox"/>	ONCOLOGY (NO SURGERY)	<input type="checkbox"/>
COLON & RECTAL SURGERY	<input type="checkbox"/>	OPHTHALMOLOGY	<input type="checkbox"/>
DERMATOLOGY (NO SURGERY)	<input type="checkbox"/>	ORTHOPAEDIC SURGERY (EXCLUDING SPINE)	<input type="checkbox"/>
DERMATOLOGY (SURGERY)	<input type="checkbox"/>	ORTHOPAEDIC SURGERY (INCLUDING SPINE)	<input type="checkbox"/>
EAR NOSE AND THROAT (NO SURGERY)	<input type="checkbox"/>	PAEDIATRICS (NO SURGERY)	<input type="checkbox"/>
EAR NOSE AND THROAT (SURGERY)	<input type="checkbox"/>	PAEDIATRICS (SURGERY)	<input type="checkbox"/>
EMERGENCY MEDICINE (NO MAJOR SURGERY)	<input type="checkbox"/>	PERINATOLOGY	<input type="checkbox"/>
EMERGENCY MEDICINE/TRAUMA (INCLUDES MAJOR SURGERY)	<input type="checkbox"/>	PHYSICAL MEDICINE AND REHABILITATION	<input type="checkbox"/>
ENDOCRINOLOGY	<input type="checkbox"/>	PLASTIC SURGERY	<input type="checkbox"/>
GASTROENTEROLOGY (NO SURGERY)	<input type="checkbox"/>	PODIATRISTS (ABOVE THE ANKLE)	<input type="checkbox"/>
GASTROENTEROLOGY (SURGERY)	<input type="checkbox"/>	PODIATRISTS (BELOW THE ANKLE)	<input type="checkbox"/>
GENERAL SURGERY (EXCLUDING BARIATRIC)	<input type="checkbox"/>	PSYCHIATRY	<input type="checkbox"/>
GENERAL SURGERY (INCLUDING BARIATRIC)	<input type="checkbox"/>	PULMONARY DISEASES	<input type="checkbox"/>
GYNAECOLOGY (NO SURGERY)	<input type="checkbox"/>	RADIOLOGY DIAGNOSTIC & THERAPUTIC INCLUDING INTERVENTIONAL & RADIATION TX	<input type="checkbox"/>
GYNAECOLOGY (SURGERY)	<input type="checkbox"/>	RADIOLOGY DIAGNOSTIC & THERAPUTIC	<input type="checkbox"/>
HAND SURGERY	<input type="checkbox"/>	RADIOPAQUE DYE	<input type="checkbox"/>
HEAD AND NECK SURGERY	<input type="checkbox"/>	RHEUMATOLOGY	<input type="checkbox"/>
HAEMATOLOGY (NO SURGERY)	<input type="checkbox"/>	SPORTS MEDICINE	<input type="checkbox"/>
IMMUNOLOGY	<input type="checkbox"/>	THORACIC SURGERY	<input type="checkbox"/>
INTENSIVE CARE MEDICINE	<input type="checkbox"/>	UROLOGY (NO SURGERY)	<input type="checkbox"/>
MAXILLOFACIAL SURGERY	<input type="checkbox"/>	UROLOGY (SURGERY)	<input type="checkbox"/>
NEONATOLOGY (CRITICAL CARE)	<input type="checkbox"/>	VASCULAR SURGERY	<input type="checkbox"/>
NEONATOLOGY (NON-CRITICAL CARE)	<input type="checkbox"/>	OTHER - PLEASE SPECIFY	<input type="checkbox"/>
NEOPLASTIC DISEASES (NO SURGERY)	<input type="checkbox"/>	<input type="text"/>	

Please provide full details of all private work for which indemnity is required:

## Section 2 – Practice Profile Continued

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

a) Private Practice

%

b) HSE

%

3. If you are a surgeon, please state the average number of private practice surgeries per year.

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

Yes

No

5. Is all work performed within the Republic of Ireland?  
(If "No", where? Please use additional space provided in Section 5)

Yes

No

## Section 3 – Professional History

1. What year did you begin private practice?

YYYY

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

Indemnity/Insurance Provider

Year First Joined

Renewal / Expiry Date

Subscription in Current Year

DD/MM/YY

€

3. Has your indemnity been continuous since qualification?

(If "No", please provide details in Section 5)

Yes

No

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

(If "Yes", please provide details in Section 5)

Yes

No

5. 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 a print out of all cases from your current and previous indemnifier(s) or insurer(s), if any.)

Yes

No

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

(If "Yes", please provide the relevant date with brief details using additional space in Section 5)

Yes

No

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

Yes

No

8. 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 IMC Fitness to Practice procedures?

(If "Yes", please provide brief details in Section 5)

Yes

No

## Section 4 – Financial Information

1. What is your gross annual income from your private practice, **excluding** both medico-legal and HSE indemnified work?

a) for the past accounting year?

€

b) estimated for the current accounting year?

€

2. What is your gross annual income from **medico-legal work only** in your private practice?

a) for the past accounting year?

€

b) estimated for the current accounting year?

€

3. What are your total practice expenses as declared to The Office of the Revenue Commissioners in the last accounting year?

€

4. Do you provide your services or bill your patients via a Limited Company, or a similar joint venture?

(If "Yes", please complete 4. a), b), c) and d).)

Yes

No

a) If applicable, please provide the company name and number.

Company Name

Number

b) Are you the only registered medical practitioner working for the Company?

Yes

No

c) Does the Company or you employ medically qualified and/or auxiliary staff?

Yes

No

d) If applicable, do you require cover for any of the staff included in 4. c) 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.

Printed Name of Applicant

Applicant's Signature

Date of Signature