challenge

# General Practitioner Application Form

## 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 5 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: Select
3. Forename:
3. Surname:
4. Date of Birth: Day Month Year
5. Gender: Male ☐ Female ☐
6. Home Address (for all correspondence):
7. Email Address:
8. Mobile No.:
9. Practice Website:
10. Practice Address:
11. Medical Council Registration No.:
    Refer if no valid IMC registration
12. IMC Registration Type: Please Select

## Section 2 – Practice Profile

13. 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. Normal GP Work (private incl. medical card scheme) ☐ ii. Out of Hours / Locum Work ☐

    iii. Accident and Emergency Work ☐ Iv. Urgent Care ☐ v. Non-Surgical Cosmetic/Aesthetic (i.e. Botox/Fillers) ☐

    Total number of weekly sessions ☐

## Section 2 – Practice Profile *(continued)*

14. Do you undertake telephone or video conferencing with any of your patients? Yes ☐ No ☐
15. i) Are you engaged in the provision of medical support/services for professional sports clubs or associations? Yes ☐ No ☐
    ii) If Yes, do you need coverage for these services? Yes ☐ No ☐
16. Do you undertake or take part in the administration of clinic trials? Yes ☐ No ☐
17. As part of your role are you required to appraise and/or train your colleagues? Yes ☐ No ☐
18. Do you plan to cease all practice within the next 5 years? Yes ☐ No ☐
19. 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 (14-19), please provide full details below**

## Section 3 – Professional History

20. In which year did you qualify?
21. Are you qualified to practice as a GP in the Republic of Ireland? Yes ☐ No ☐
22. Have you had medical indemnity in the Republic of Ireland before? Yes ☐ No ☐

Please provide details of current insurance, if applicable.

i. Indemnity/Insurance provider
ii. Year first joined
iii. Renewal/Expiry Date Day Month Year
iv. Subscription in current year

23. Has your indemnity been continuous since qualification? Yes ☐ No ☐
24. 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 ☐
25. 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 4) Yes ☐ No ☐
26. Are you aware of any circumstances from your practice which may give rise to a claim against you? Yes ☐ No ☐
27. Have all of the above circumstances been notified to your current indemnity provider or insurer? Yes ☐ No ☐
28. 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 – Additional Information

## Section 5 – 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 Day Month 2022