challenge

Specialist Practitioner Application Form

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
Challenge House
Willie Nolan Road
Baldoyle
Dublin 13

Email: insurance@challenge.ie
Tel: +353 1 8395942
Fax: +353 1 8324254

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 | Forename | Surname

Date of Birth (DD / MM / YY) | Male ☐ | Female ☐

Home Address (for all correspondence)

Postcode

Practice Addresses

Email Address

Contact No.

Mobile No.

Practice Website

IMC Specialist Registration No.

Registration Type | Full ☐ | Limited ☐ | Provisional ☐

In which country did you complete your fellowship?

Section 2 – Practice Profile

1. Please indicate your specialty.

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

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? Yes ☐ No ☐
(If "No", where? Please use additional space provided in Section 5)

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
	YYYY	DD/MM/YY	€

3. Has your indemnity been continuous since qualification? Yes ☐ No ☐
(If "No", please provide details in Section 5)

4. 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 ☐
(If "Yes", please provide details in Section 5)

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? Yes ☐ No ☐
(If "Yes", please provide a print out of all cases from your current and previous indemnifier(s) or insurer(s), if any.

6. Are you aware of any circumstances, from your public or private practice, which may give rise to a claim against you? Yes ☐ No ☐
(If "Yes", please provide the relevant date with brief details using additional space in Section 5)

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? Yes ☐ No ☐
(If "Yes", please provide brief details in Section 5)

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? Yes ☐ No ☐
(If "Yes", please complete 4. a), b), c) and d).)

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