



JMM INSURANCE (IRELAND) LIMITED

PHARMACY

PROFESSIONAL INDEMNITY & PRODUCTS' LIABILITY PROPOSAL FORM

Harcourt Centre,
Block 4, Harcourt Road,
Saint Kevin's
Dublin 2,
D02 HW77

Directors: Julian Berry (GBR) • Evan Whelan

Registered Office: Harcourt Centre, Block 4, Harcourt Road, Saint Kevin's,
Dublin 2, D02 HW77

Registered number: 595307 • JMM Insurance (Ireland) Limited, trading
as JMM Europe, is regulated by The Central Bank of Ireland

Broker at **LLOYD'S**

Coverholder at **LLOYD'S**



Important information – Please read the Important Information below. Important Note overleaf and the fact sheet Information about our Insurance Services before completing this form.

1. Your cover will not start until we have accepted this proposal. We reserve the right to refuse acceptance of any proposal for insurance. No liability is undertaken by us in connection with this proposal until cover has been issued with our authority.
2. By completing this application, you consent to accept the Policy Terms & Conditions. A copy of the Policy Document is available on request. You also agree that you have read the policy summary and the leaflet about our insurance services.

General Information

Full Name of Proposer:

Name

Are you a:

Sole Trader **Partnership** **Limited Company**

IPU Membership Number:

Number

PSI Registration Number:
(except Dispensary Assistant)

PSI Number

Date Registered with PSI:

Date

Company Name:

Company Name

Trading Name:

Trading Name

Address:

Street Name & Number



Number of Pharmacies to be Insured

Please list names and addresses of all shops:

1. Name & Address

2. Name & Address

3. Name & Address

4. Name & Address

5. Name & Address

*Please list any other shop on a supplementary sheet.

Date you wish insurance to commence:

Retroactive Date*
(if applicable)

*The date from which you have held uninterrupted Professional Indemnity Insurance. In the event of a claim you will be asked to provide evidence of this insurance.

Do you provide Patient Care Services?
(Blood Tests, Vaccinations, Blood Pressure Checks etc)

Yes No

What percentage of your annual turnover is made up by these services?

City:

County:

Post Code:

Telephone Number:

Email Address:



General Questions

Are there any claims or prosecutions currently being made against you alleging negligent act, error or omission, which may genuinely and reasonably be expected to result in a claim?

Yes No

Are you aware of any circumstances which have already occurred which might genuinely and reasonably be expected to result in a claim?

Yes No

Have you ever been refused similar insurance, been quoted increased premiums or had special conditions imposed?

Yes No

Have you had similar insurance previously?

If yes, please provide insurance company and policy number on the below line.

Yes No

What is the turnover of your company per annum?

Amount

If you have answered Yes to questions 1 – 3, please give full details on a supplementary sheet of paper and sign and date it.

Have you ever been, or do you have reason to expect to be:-

a. Bankrupt, insolvent or subject of a credit judgement?

Yes No

b. Director of a liquidated Company?

Yes No

c. Prosecuted for Health and Safety offences:

Yes No

d. Been convicted of or charged (but not yet tried) with a criminal offence?

Yes No

If you answered Yes to any of the above listed questions, please provide details

Details



Important Notice

Before you sign the following declaration, please make sure that you have answered all the questions relating to the cover you require and not deliberately ignored information. It is essential that you disclose accurately all facts which could influence acceptance of this application or terms to be applied. If you are not sure whether to include certain information, please do so anyway. If you do not tell us something relevant, your insurance may not be valid.

Declaration

I declare that to the best of my knowledge and belief, the information provided which I have read and checked is true, accurate and complete. I am willing to accept the terms and conditions of JMM Europe policy and I undertake to pay premium when called to do so.

The signatory must be a person who is authorised to deal with your insurance policy.

Name

Full Name

Position

Position

Signature

Date

Date

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- **Your cover will not start until we have accepted this proposal.**
- **We have the right to reject any proposal.**

Data Protection Notice

This notice is written to comply with the General Data Protection Regulations (GDPR) and provides information about how JMM Insurance (Ireland) Limited collects, uses, shares and stores personal data in the capacity as a 'Data Controller'. For further details please refer to our privacy Policy <https://jmm ltd.eu/privacy-policy/>