PROPOSAL FORM
Medical Malpractice
Ambulance Service

iTOO™
In association with Hollard.

PLEASE READ BEFORE COMPLETING THIS DOCUMENT

This is a proposal for a claims made policy.

The policy will only respond to claims and/or circumstances, which are first made against the Insured and notified to the Insurer during the policy period.

The policy will NOT provide cover for:

- Events that occurred prior to the retroactive date of the policy.
- Claims made after the expiry of the policy period even though the Wrongful Act giving rise to the claim may have occurred during the policy period.
- Claims notified or arising out of facts or circumstances notified under any previous policy or noted on the current proposal form or any previous proposal form.
- Claims made, threatened or intimated prior to the commencement of the policy period.
- Facts or circumstances in your knowledge prior to the policy period, which you knew had the potential to give rise to a claim under the policy.

Documents required:

- Completed, signed and dated proposal form
- Copy of HPCSA Registration and Department of Health Registration
- CV and copy of all qualifications (New Applications or change in scope of practice)
- Consent Form (only if the client provides ambulance / paramedical services at Events)
- Patient Report Form
- Proof of previous insurance (if moving from another insurer) (New Applications or change in scope of practice)
- Claims Information (if applicable)
- Annexure A to be completed if services rendered at events
- Example of incident register maintained

The Proposal form comprises of:

Section One	Your Organisation
Section Two	Activities of Proposer
Section Three	Risk Management
Section Four	Declaration

Every question on the proposal form is relevant to your risk, so please do not leave any blank, if it doesn't apply please state "N/A". If there is any part of this document you do not understand, please contact your broker before you sign and submit it. You are bound to the information you have provided with this submission.

IT IS ADVISABLE TO INSURE INDEPENDENTLY OPERATING BRANCHES OR SUBSIDIARY COMPANIES WHICH ARE REMOVED FROM THE DIRECT CONTROL OF HEAD OFFICE UNDER A SEPARATE POLICY

Section One – Your Organisation

1. **Application Type** New Application ☐ Scheduled Review Application ☐ Additional/Changed Scope of Clinical Practice ☐
2. **Your Organisation**

Proposers Name _____

ID Number (If sole Trader) _____

Incorporation details (if any) _____

Trading name (if different from the above) _____

Please provide your VAT registration number _____

Company Registration Number _____

Medical Council registration number _____

Practice Number _____

iTOO Special Risks (Pty) Ltd | Company Registration No: 2016/281463/07
Villa Arcadia, 22 Oxford Road, Parktown, Gauteng, 2193 | PO Box 87419, Houghton, 2041
Tel: 011 351 5000 | Email: info@itoo.co.za

Physical Address _____ code _____

Postal Address _____ code _____

Email _____

Telephone _____

Website _____

If cover is required for more than one location, please attach a list of all addresses

_____

_____

_____

3. Please give a full description of your business activities for which cover is required

_____

_____

_____

4. Name and Qualifications of Directors and Key Personnel

Name	Position Held	Qualifications	Date Qualified

5. Which associations, professional bodies or self – regulatory organisations is the insured a member of or registered with

Which Body	Membership Number	Period of Membership

6. Is the organisation a member of Disaster Risk Management Institute of South Africa (DMISA)? Yes ☐ No ☐

7. Is the organisation a member of Emergency Medicine Society of SA (EMSSA)? Yes ☐ No ☐

8. Has any membership or registration with such organisation/body ever been suspended, withdrawn, amended, declined or had any specific conditions attached Yes ☐ No ☐

If YES, please provide full details on a separate page

9. Confidential Professional Information / Claims

9.1 Have any circumstances /complaints/claims of professional negligence, error or omission or public liability that have been made against the Practice or any of the present or past Principals, whether insured or not, in the past 5 years? Yes ☐ No ☐

If YES, please provide full details on a separate page including Date of claim /Total value claimed, total value paid (if paid) / Description / Nature of allegations

9.2 Are any of the Principals or Employees of the practice, after enquiry, aware of any circumstances that may give rise to a claim for professional negligence, errors or omissions or public liability? Yes ☐ No ☐

If YES, please provide full details on a separate page

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9.3 Have any Principals or Employees of the practice had any civil or criminal actions where there was a finding of liability or guilt? Yes ☐ No ☐

If YES, please provide full details on a separate page

9.4 Has any application for insurance of this nature (made on behalf of the Practice or their pre-decessors in business or by any of the present Partners) ever been declined, cancelled or has renewal been refused or have special terms been imposed ? Yes ☐ No ☐

If YES, please provide full details on a separate page

9.5 Have you or any Principals or Employees ever been investigated, or are currently under inves-tigation by the HPCSA / relevant professional regulatory body overseas / medical scheme? Yes ☐ No ☐

If YES, please provide full details on a separate page

10. Insurance History

Have you or are you presently Insured in respect of Medical Malpractice Yes ☐ No ☐

If Yes, please provide the following information

Name of Insurers _____

Limit of Indemnity _____

Deductible _____

Retroactive Date _____

Annual Premium _____

Section Two – Activities of the Proposer

11. Do you undertake any services of a state-owned facility / government hospital or clinic? Yes ☐ No ☐

If yes, please provide full details

_____

_____

_____

12. Are you an employee of an institution? Please state name of entity for which you work Yes ☐ No ☐

(Applicable to Individuals)

_____

13. Revenue / Fees (Gross) (Inclusive of VAT)

Financial Year End:	Last Financial Year	Previous Financial Year	Estimated forthcoming 12 months
Gross revenue from fees			
Gross revenue from other sources			
Total			

14. Staff (Should there not be sufficient space – please complete and provide separate annexure)

a) Fully Qualified and Trained Paramedics

Name	HPCSA Registration No	Qualifications	Experience

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b) Trainee Paramedics

Name	HPCSA Registration No	Qualifications	Experience

c) Volunteers

Name	HPCSA Registration No	Qualifications	Experience

d) Other Staff

Name	HPCSA Registration No	Qualifications	Experience

15. Staff Count

	Current Year	Prior Year
Principals		
Number of basic ambulance assistants (BAA / ECA'S)		
Number of ambulance emergency assistants (ILS)		
Number of advanced life support medics (ALS)		
Volunteers / Part Time		
Other:		
Total	0	0

16. Ambulances

	Current Year	Prior Year
Number of ambulances in operation		
The minimum qualification for ambulance crew members		
Number of crew members per ambulance per category		
a) Basic Ambulance Assistants		
b) Ambulance Emergency Assistants		
c) Fully trained/ qualified paramedics		
d) Other		

17. Rapid Response Vehicles

	Current Year	Prior Year
Number of rapid response vehicles in operation		
The minimum qualification of rapid response vehicle crew members		

Are all vehicles i.e. Ambulances and rapid response vehicles fully equipped to handle any/all emergencies: Yes ☐ No ☐

NO, please specify:

Number of crew members per vehicle per category		Current Year	Prior Year
a) Basic Ambulance Assistants			
b) Ambulance Emergency Assistants			
c) Fully trained/ qualified paramedics			
d) Other			

18. Please provide details

	Ambulances	Rapid response vehicles
The approximate number of emergency calls per month		
The approximate number of routine trips to hospital/ inter-hospital transfers per month		
The average approximated radius of operations		

19. Number of shifts and hours worked per shift of crew members (ambulances and rapid response vehicles)

		Number of shifts	Hours per shift
Basic Ambulance Assistants			
Ambulance Emergency Assistants			
Advanced Life Support Staff			
Other : (Specify)			
Other : (Specify)			

20. Is an air ambulance repatriation service maintained Yes ☐ No ☐

Please provide details:

21. The territories in which you expect to operate

22. Number of repatriations per annum

23. Do you undertake any services in respect of event, if yes complete **Annexure A** Yes ☐ No ☐

cover for events is not automatically included if not disclosed

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Section Three – Risk Management

24. Does any staff have any physical or mental condition or substance abuse problems that could affect your ability to safely and competently undertake the provision of care? Yes ☐ No ☐

    If yes, please provide full details

25. Does any person involved in the treatment and care of any patient/client suffer from any disability, transmittable diseases i.e. Hepatitis, HIV etc. or any other impediments which may affect the performance of his/her professional duties or place any patients/clients at risk? Yes ☐ No ☐

    If yes, please provide full details

26. Are accurate and descriptive records of all medical services and procedures kept Yes ☐ No ☐

27. What system is in place for capture patient notes?

    _____

    _____

    _____

28. How are your patient records secured?

    _____

    _____

    _____

29. How long do you retain patients medical records?

    _____

    _____

    _____

30. Please detail procedures in place in dealing with patient complaints:

    _____

    _____

31. Do you have an internal risk management protocol? Yes ☐ No ☐

    Please provide copy of protocol

32. Disposal of Medical Waste

    Are there facilities for safe collection, storage and disposal of (in accordance with current guidelines/legislation)

    a. Sharps Yes ☐ No ☐

    b. Dressings, clinical and surgical waste, etc. Yes ☐ No ☐

    Do you ensure that the following are safely disposed of (in accordance with current guidelines/legislation)

    a. Blood and blood products Yes ☐ No ☐

    b. All other waste Yes ☐ No ☐

Limit of Indemnity and Deductible Required

Limit:	_____	Deductible:	_____
Limit:	_____	Deductible:	_____
Limit:	_____	Deductible:	_____
Limit:	_____	Deductible:	_____

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Section Four – Declaration

Privacy

In order to provide you with insurance, we have to process your personal information. We will share your personal information with other insurers, industry bodies, credit agencies and service providers. This includes information about your insurance, claims and premium payments. We do this to provide insurance services, prevent fraud, assess claims and conduct surveys. We will treat your personal information with caution and have put reasonable security measures in place to protect it. By signing this application for insurance, you agree to the processing and sharing of your personal information.

Declaration

I/We, the undersigned, declare that the statements set forth in this proposal form together with any other information supplied are true and correct and that I/we have not misstated or suppressed any material facts.

I/We agree that this proposal form together with any other information supplied by me/us shall form the basis upon which the contract of insurance is concluded and shall be incorporated therein.

I / We understand that any incorrect statement in this application and the attached supporting documents including (but not restricted to) qualifications, experience, scope of practice, ability, physical or mental health or personal integrity, may result in refusal of a cover.

I/We further undertake that in the event that the information provided changes between the date of this application and inception of cover, I/We will notify iToo of such changes as soon as reasonably possible.

You are bound to the information you have provided with this submission. Completion of the form, however, does not bind you or Insurers to complete the insurance transaction. The contract of insurance can only be finalized once we are in receipt of the fully completed and signed proposal form together with acceptance of quotation and payment. Any new additional entity being formed, or any material changes made to the business which could impact the cover provided must be advised to insurers as cover will not automatically be granted.

_____	_____	Y	Y	Y	Y	M	M	D	D
Signature of Proposer	Name of Proposer (print)	Date							

_____

Designation

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