PROPOSAL FORM

Medical Malpractice

Beauticians | Spas | Personal Beauty Treatments

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
- CV and copy of all qualifications (New Applications or change in scope of practice)
- Consent Forms
- Proof of previous insurance (if moving from another insurer) (New Applications or change in scope of practice)
- Claims Information (if applicable)
- Product menu / services offering menu

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 1 – Your Organisation

Application Type New Application ☐ Scheduled Review Application ☐ Additional / Change in Activities and/or Services ☐

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

Physical Address _____ code _____

Postal Address _____ code _____

Email _____

Telephone _____

Website _____

3 August 2020

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

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. 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

7. Confidential Professional Information / Claims

7.1 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

7.2 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

7.3 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

7.4 Has any application for insurance of this nature (made on behalf of the Practice or their predecessors 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

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

If YES, please provide full details on a separate page

7.6 Is there any additional information that may have significance, when we assess the risk. Yes ☐ No ☐

Please provide relevant brochures, standard contract conditions on a separate page.

8. 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

9. 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			

10. Consultations / Treatments

a. In the last 12 months, how many clients have you consulted with (actual) _____

b. Expected number of consults in the next 12 months _____

11. Please indicate what standard approved beauty treatments you perform

Note: No cover for any treatments not approved or not standard to the beauty industry or any trial treatments/procedure

Body Wrapping		Caci (Facial Technique)	
Electrical Epilation/Hair removal		Ear Piercing	
Eyebrow Tinting/shaping		Facials	
Hairdressing		Lash tinting	
Manicure		Make up	
Nail extensions		Pedicures	
Sun bed		Spa treatments	
Sugaring		Tanning applications	
Waxing		Laser hair removal	
Botox		Chemical peels (maximum 30%)	
Dermal Fillers		Radiation Treatments	
Microdermabrasion		Laser vein removal	
Electrolysis		Photo rejuvenation	
Tattoo Removal		Cryptherapy	
Microneedling		Cupping	
Other:		Other:	

12. Aesthetics

Indicate below which Aesthetic procedures you currently perform (if any)

1. Botox Injections Yes ☐ No ☐

2. Fillers Yes ☐ No ☐

3. Threads Yes ☐ No ☐

4. Other

The following information will be required prior to granting cover:

a. Please provide proof of all qualifications and or courses that you have undertaken, in respect of Aesthetics.

b. A copy of the certificate in dealing with emergency situations

c. How far (km) is the closest emergency rooms? _____

d. What are the emergency protocols and procedures? _____

e. Is it a sterile facility? Yes ☐ No ☐

Please complete on a separate page

13. Is there any Aesthetic treatment being provided? Yes ☐ No ☐

If 'yes' please specify

_____

_____

_____

_____

14. List the type of products you supply to patients / clients

Note: No cover for any products used in treatment / procedures that are not approved and registered in terms of legislation as amended from time to time

_____

_____

_____

_____

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

Name	Position	Qualifications	Experience

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

16. Staff Count

	Current Year	Prior Year
Principals / Partners		
Beauty Therapists		
Medical Practitioners Employed		
Medical Practitioners Contracted		
Administrative Staff		
Other:		
Total	0.00	0.00

17. Please provide full details of any equipment used to perform treatments or therapy (on a separate sheet or use the space below) and attach any relevant brochure

18. Please provide details any subcontracted functions or facilities

19. Do you ensure subcontractors carry their own insurance Yes ☐ No ☐

Section Three – Risk Management

20. 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

21. 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

22. Are accurate and descriptive records for all services, treatment and procedures kept ? Yes ☐ No ☐

23. What system is in place for capture treatment notes?

24. How are your treatment records secured?

25. How long do you retain treatment records?

26. Please detail procedures in place in dealing with client / customer complaints

27. Are all side effects, risks and possible failure of treatment and procedures discussed with client / patient prior to treatment being undertaken ?

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

28. Are there after / post treatment protocols in place ?, and is this discussed with client / patient ? (Please detail)

_____

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

Please provide copy of protocol

30. 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: _____

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

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