

# PROPOSAL FORM

## Medical Malpractice

### Beauticians | Spas | Personal Beauty Treatments



#### 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 \_\_\_\_\_

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

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

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**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		Cryotherapy	
Microneedling		Cupping	
Other:		Other:	



**16. Staff Count**

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

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18. Please provide details any subcontracted functions or facilities

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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?

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24. How are your treatment records secured?

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25. How long do you retain treatment records?

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

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

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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

<b>Limit of Indemnity and Deductible Required</b>	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.

\_\_\_\_\_  
 Signature of Proposer                      Name of Proposer (print)

Y	Y	Y	Y	M	M	D	D
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Date

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 Designation