PROPOSAL FORM

Medical Malpractice

Individual Fitness Instructors

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 regulatory body registration
- CV and copy of all qualifications (New Applications or change in scope of practice)
- Copy of all consent forms and membership joining application
- Claims Information (if applicable)

The Proposal form comprises of:

Section One	Applicant Details
Section Two	Activities of the 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.

Section One – Applicant Details

1. Application Type New Application ☐ Scheduled Review Application ☐ Additional/Changed Scope of Practice ☐
2. Applicant Details

Proposers Name ______________________

ID Number (If sole Trader) ______________________

Trading name (if different from the above) ______________________

Please provide your VAT registration number ______________________

Company Registration Number (if applicable) ______________________

Physical Address ______________________ code ________

Postal Address ______________________ code ________

Email ______________________

Telephone ______________________

Website ______________________

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

www.itoo.co.za
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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. Please provide relevant brochures, standard contract conditions on a separate page.

   ____

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   ____

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 _______________________

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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			
Gross fees excluding VAT			
Gross revenue from other sources			
Total			

10. Type of Instruction

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

Fitness Instructor/ PT/GI		Tai Chi	
Personal Trainer		Pilates	
Gym Instructor		Rehabilitation Exercises	
Aerobics Instructor		Yoga	
Aqua Aerobics Instructor		Nutritional advice	
Exotic Dancing Instructor (Adults)		Dancing	
Taebo (no contact)		Other:	
Muscle Stimulation Training		Other:	
Other:		Other:	

11. List the type of products you supply to clients (e.g. supplements etc)

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

12. Are you undertaking freelance work or contracted to at a gym Yes ☐ No ☐

Please provide details of Fitness Club

Name of Club	Type of Contract (Part Time / Full Time)	Region

13. Do you provide any private sessions at homes

14. Do you have your own studio or renting out space in a gym

15. Do you have your own your own equipment or rent equipment to be used

16. Does the training space accommodate classes as legally required

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17. What is the age group profile to whom you provide training to

18. Do you train anyone under the age of 16 and over the age of 60

19. Are any classes provided to pregnant women ? Yes ☐ No ☐

Do you require confirmation if their medical practitioner has provided consent to be able to participate in the training activities ? (Expectant / pregnant clients must have a medical practitioners letter giving permission to undertake relevant exercise programs) Yes ☐ No ☐

20. Do you offer any aqua – fitness classes Yes ☐ No ☐

If yes, where are they undertaken?

21. Are you trained to perform CPR training and (including being able to remove someone from the pool in the event of an emergency) Yes ☐ No ☐

please provide details

22. Typical Number of sessions per week per client?

23. Typical length of a training session?

24. Please provide details of any subcontracted functions or facilities

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

Section Three – Risk Management

26. What are the protocols and procedures in place in respect of emergencies

27. Do you have 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 attach full details

28. 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 attach full details

29. Are accurate and descriptive records of all training services rendered to client maintained? Yes ☐ No ☐

30. What system is in place for capturing of training services provided?

31. How are your records secured?

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32. How long do you retain client records?

33. Please detail procedures in place in dealing with complaints

Limit of Indemnity and Deductible Required	Limit:		Deductible:	
	Limit:		Deductible:	
	Limit:		Deductible:	
	Limit:		Deductible:	
	Limit:		Deductible:	
	Limit:		Deductible:	

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.

Section Four – Declaration

I declare that I am the person named in this application and that, to the best of my knowledge, information and belief, the statements contained in this application and the attached supporting documents are true.

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

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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