PROPOSAL FORM

Medical Malpractice

Individual Healthcare Practitioners

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 / AHPCSA Registration
- CV and copy of all qualifications (New Applications or change in scope of practice)
- Copy of all consent forms used in practice
- Copy / Example of records used in practice (New Applications or change in scope of practice)
- Proof of previous insurance (if moving from another insurer) (New Applications or change in scope of practice)
- Claims Information (if applicable)
- Addendum 1 to be completed in respect of Psychologists and similar professions

The Proposal form comprises of:

Section One	Applicant Details
Section Two	Scope of Clinical Practice
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 – Applicants Details

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

Full Name _____

Date of birth: 00/00/0000 Y Y Y Y M M D D

ID Number _____

Incorporation details (if any) _____

Trading name (if different from the above) _____

Please provide your VAT registration number _____

Medical Council registration number _____

How long have you been in practice? Current Practice ☐ Years in Practice ☐

Practice number (if applicable) _____

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Practice Address _____ code _____

Postal Address _____ code _____

Email _____

Telephone _____

Website _____

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

_____

_____

_____

Please provide list of Licensing / Registration Body with which you a hold a valid licence / membership?

_____

_____

_____

Are you a member of any Association? Yes ☐ No ☐

if Yes, who and for how long?

_____

_____

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

_____

_____

_____

4. Please list all your registered qualifications including any post – graduate qualifications, where and when this was obtained

_____

_____

_____

5. Confidential Professional Information / Claims

5.1 Have any claims / incidents / circumstances for malpractice been made against you / practice during the past five 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

5.2 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

5.3 Have you had any civil or criminal actions against you, where there was a finding of liability or guilt with respect to your clinical practice? Yes ☐ No ☐

If YES, please provide full details on a separate page

5.4 Has a criminal claim of any nature ever been made against you / your practice? Yes ☐ No ☐

If YES, please provide full details on a separate page

5.5 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

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5.6 Have you 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

5.7 Do you 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 attach full details

5.8 Do you employ Locums to assist you at your practice Yes ☐ No ☐

If YES, kindly ensure that all Locums have their own Professional Indemnity / Medical Malpractice Policy in place, as their activities will not be covered in terms of your Policy

5.9 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

5.10 Is there any additional information that may have significance, when we assess your individual risk, for example full time Hospital employment, academic involvement, registrar, etc

_____

_____

_____

6. 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 – Scope of Clinical Practice

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

_____

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

_____

9. Do you undertake any locum work? If yes, please detail locum work Yes ☐ No ☐

_____

10. If a practice, please provide list of all staff in the practice

Name	Position	Qualification	Part Time / Full Time

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

Financial Year End:	Last Financial Year	Previous Financial Year	Estimated forthcoming 12 months
Gross revenue from private practice			
Gross revenue from state institutions			
Gross fees excluding VAT			
Gross revenue from other sources			
Total			

12. Patients

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

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

c. Total number of treatments / sessions / consultations in the last 12 months (actual) _____

d. Expected number of treatments / sessions / consultations in the next 12 months _____

13. In what AREA or branches of HEALTHCARE are you qualified and, if applicable, licensed to practice

Acupuncture		Aromatherapist	
Audiologist/speech therapist		Biokinenticist	
Chinese medicine		Chiropractor	
Cytologist		Dermatologist	
Dietician		Homeopathy	
Haematologist		Medical technologist	
Natureopathy		Medical Lab Technician	
Nutritionist		Optometrist	
Orthotist/prosthetist		Occupational therapist	
Osteopathy		Pathologist	
Physiotherapist		Podiatrist	
Psychiatrist		Psychologist	
Prosthetist/Orthotist		Radiographer	
Radiologist		Reflexologist	
Sexologist		Sports scientist	
Other:		Other:	

14. Additional Information

14.1 What equipment if any is being used to perform treatments

_____

14.2 What is the age group breakdown of the patients you provide treatment to

_____

14.3 Do you prescribe and/or supply any products (including medicines, creams etc.) Yes ☐ No ☐

If yes, please provide :

Product	Use (Internal / External)	Supplier / Producer	Approx. Fees

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Section Three – Risk Management

15. Risk Management

15.1 Is it Mandatory that all your patients sign a consent form for consultations? Yes ☐ No ☐

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

15.3 What system is in place for capture patient notes?

_____

_____

_____

15.4 How are your patient records secured?

_____

_____

_____

15.5 How long do you retain patients' medical records?

_____

_____

_____

15.6 Please detail procedures in place in dealing with patient complaints

_____

_____

_____

_____

_____

_____

_____

_____

15.7 Do you have an internal risk management protocol? Please provide copy of protocol Yes ☐ No ☐

16. 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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