PROPOSAL FORM

Medical Malpractice

Pharmacists and Pharmacies

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 South African Pharmacy Council certificate
- CV and copy of all qualifications (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)

The Proposal form comprises of:

Section One Applicant Details
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.

Section One – Applicant Details

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

Full Name _____

ID Number (If sole Trader) _____

Incorporation details (if any) _____

Trading name (if different from the above) _____

Please provide your VAT registration number _____

Council registration number _____

Practice number (if applicable): _____

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

Physical Address _____ code _____

Postal Address _____ code _____

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

Email _____

Telephone _____

Website _____

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

_____

_____

_____

3. Activities of Pharmacy or Pharmacist

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

_____

_____

4. Please state the owner (s) names and details of their experience and qualifications

Name	Shareholding %	Experience and Qualifications

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 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 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

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

(Applicable to Individuals)

_____

11. *How many scripts were dispensed in the past financial year ?*

_____

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

Financial Year End:	Last Financial Year	Previous Financial Year	Estimated forthcoming 12 months
Gross revenue from fees including income of sale of goods			
Gross Revenue in respect of dispensing of medication			
Other			
Total	0.00	0.00	0.00

13. Does the pharmacy operate/run a clinic from/in the pharmacy: Yes ☐ No ☐

Please detail scope of services

_____

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

a) Pharmacist Details

Name	Pharmacy Council Number	Qualifications	Experience

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15. Staff Count

	Current Year	Prior Year
Responsible pharmacists		
Pharmacists, excluding principals / owners		
Pharmacy assistants / interns/ students		
Retail / State / Industrial		
Retail / State Principal		
Other: e.g. Wholesalers / Regulatory Affairs		
Industrial Management		
Locums		
Nurses / Pharmacy Clinic Sisters		
Other:		
Other:		
Total		

16. Are you a Pharmaceutical Society Member (PSSA) Yes ☐ No ☐

If yes, please provide full details

17. Are you a member of any other Pharmaceutical Association / Society, if so please indicate Yes ☐ No ☐

18. Has the Institution been issued with the necessary licence by the local authority, enabling it to trade legally at the premises Yes ☐ No ☐

Section Three – Risk Management

19. Do any staff 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

20. 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

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

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

23. How are your patient records secured?

24. How long do you retain patients' medical records?

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

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

Please provide copy of protocol

27. 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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