iTOO™

In association with Hollard.

PROPOSAL FORM
Medical Malpractice Beauticians

Hollard.

Underwritten by The Hollard Insurance Co. Ltd,
an authorised Financial Services Provider

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ITOO is an Authorised Financial Services Provider. FSP No. 47230

Please answer **ALL** questions completely
Should any question or part thereof not be applicable, please state "N/A"
Should insufficient space be provided, please continue on your company letterhead

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

1. Name of Insured _____

2. Has the Insured ever carried out services under a different name **Yes** ☐ **No** ☐

   *If **YES**, please provide details*

3. Head office physical and postal address _____

   _____

4. Location of branch offices _____

5. Telephone Number _____

6. Email Address _____

7. VAT Number _____

8. Company Registration Number _____

9. Please give a full description of the Insured's business activities for which cover is required

10. 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/procedures*

Body Wrapping		**Caci (Facial Technique)**	
Electrical Epilation/ Hair Removal		**Ear Piercing**	
Eyebrow Tinting/Shaping/ Microblading		**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%)	
Microdermabrasion		Laser Vein Removal	
Electrolysis		Photo Rejuvenation	
Other:		Other:	

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

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

12. Provide full details of the sole practitioner or principals or partners or members or directors

Name	Qualification	Date Qualified	Duration in this Practice

13. Are you a member of any professional organisation and/or registered with any self-regulating body

Yes		No	

*If **YES**, please provide details (Name of organisation; period of membership; membership number)*

14. Has any membership or registration with such organisation/body ever been suspended, withdrawn, amended, declined or had any specific conditions attached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 details*

15. Please state the number of employees

Partners/Members/ Directors/ Principals		**Qualified Staff**	
Other Staff (ex. Admin)		**Administrative Staff (Typists etc.)**	
Contract Hired Staff		**Other:**	

16. 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 details*

17. Have you and/or any of your partners and/or employees ever been convicted for an act committed in violation of any law or ordinance other than traffic offences

Yes		No	

*If **YES**, please provide details*

18. When is your financial year end

	Last Financial Year End	Previous Financial Year End
Gross revenue from fees including sales of goods		
Gross revenue from other sources		
Specify:		
Total		

GENERAL INFORMATION

19. List all 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 or employees, whether insured or not, in the past 5 years

20. 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 details*

21. 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 details*

LIMIT OF INDEMNITY

Quote request	

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 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.

Name (duly authorised)

Designation

Signature

Date

D	D	M	M	Y	Y	Y	Y