



In association with **Hollard.**

PROPOSAL FORM  
Medical  
Malpractice  
Pharmacists/  
Pharmacies

**Hollard.**

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

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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

1. Name of Insured \_\_\_\_\_

2. Has the Insured ever carried out medical 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. Does the Insured have any subsidiary companies that you require cover for

Yes

No

*If YES, please provide details*


8. VAT Number \_\_\_\_\_

9. Registration Number \_\_\_\_\_

10. HPCSA Number \_\_\_\_\_

## ACTIVITIES OF PHARMACY

11. Please state the discipline(s) in which the Insured is engaged




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

Name	Shareholding (%)	Experience/Qualifications

13. Are any of the above shares held by US interests

Yes		No	
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If **YES**, please provide details


14. Pharmacist details

Name	Qualification	Date Qualified	Pharmacy Council Number

15. Please state the number of

Pharmacists, Excluding Principals/Owners		Locums	
Nurses/Pharmacy Clinic Sisters		Pharmacy Assistants/Interns/Students	
Other Staff (Assistants, Admin, Drivers, Cleaning)		Industrial Management	
Retail/State Principal		Retail/State/Industrial Employee	
Other (e.g. Wholesalers, Regulatory Affairs)		Other:	



16. Are you a Pharmaceutical Society Member (PSSA)

Yes		No	
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If **YES**, please provide membership no.


17. Are you a member of any other Pharmaceutical Association/Society, if so, indicate which Association/Society

Yes		No	
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If **YES**, please provide membership no.


18. Has membership or registration with such Association/Society ever been suspended, withdrawn, amended or declined or had any special conditions attached

Yes		No	
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If **YES**, please provide full information


19. Are patient records kept, where and how long they are retained for


20. Has the Institution been issued with the necessary licence by the Local Authority, enabling it to trade legally at the premises

Yes		No	
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21. Revenue

- a. When is your financial year end
- b. Last year's total gross annual income including income from the sale of goods
- c. Estimated total gross annual income including income from the sale of goods




## GENERAL INFORMATION

22. 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


23. 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	
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If **YES**, please provide details


24. 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, canceled or has renewal been refused or have special terms been imposed

Yes		No	
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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
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