PROPOSAL FORM

Medical Malpractice

Retirement Home Frail Care Assisted Living

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
- Admission form into facility
- Is the entity registered as a residential facility with the Department of Social Development in accordance with the Older Persons Act, 2006 (ACT NO. 13 OF 2006)- kindly provide copy of this to Insurers
- Consent forms
- Proof of previous insurance (if moving from another insurer) (New Applications)
- Claims Information (if applicable)

The Proposal form comprises of:

Section One	Your Organisation
Section Two	Activities of Proposer
Section Three	Risk Management and Protocols
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.

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

Section One – Your Organisation

1. **Application Type** New Application ☐ Scheduled Review Application ☐ Additional/Changed Scope of Clinical Practice ☐
2. **Your Organisation**
   - 2.1 Proposers Name _____
   - 2.2 Incorporation details (if any) _____
   - 2.3 Trading name (if different from the above) _____
   - 2.4 How long have you been trading under the above name? _____
   - 2.5 Have you ever carried out Medical Services under a different name? Yes ☐ No ☐
     - 2.5.1 If YES, please provide full details

_____

_____

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Tel: 011 351 5000 | Email: info@itoo.co.za

2.6 How long has current operation been managed or owned by the present parent / owner? _____

2.7 Does the Insured have any subsidiary companies that you require cover for Yes ☐ No ☐

2.7.1 If YES, please provide full details

_____

_____

_____

2.8 Do you envisage any material changes to the entity within the next 12 months? Yes ☐ No ☐

2.8.1 If YES, please provide full details

_____

_____

_____

2.9 Does the Insured's activities involve any joint ventures with another company, partnership, individual or other professional grouping Yes ☐ No ☐

2.9.1 If YES, please provide full details

_____

_____

_____

2.10 Please provide your VAT registration number _____

2.11 Company Registration Number _____

2.12 Physical Address _____ code _____

2.13 Postal Address _____ code _____

2.14 Email _____

2.15 Telephone _____

2.16 Website _____

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

_____

_____

_____

3. Please provide full description Insured 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

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5. Confidential Professional Information / Claims

5.1 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

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 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

5.4 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

5.5 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

5.6 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.

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 – Activities of the Proposer

7. Confidential Professional Information / Claims

7.1 Is the entity registered as a residential facility with the Department of Social Development in accordance with the Older Persons Act, 2006 (ACT NO. 13 OF 2006 Yes ☐ No ☐

Kindly provide copy of this to Insurers

7.2 In respect of medical services at the address specified above, are you in possession of the registered licenses and /or registrations from the applicable regulatory body, or as required by law Yes ☐ No ☐

7.3 Please provide full details all licences and / or registrations

_____

_____

_____

7.4 Which associations, professional bodies, or self – regulatory organisations is the Insured a member of or registered with

_____

7.5 Is the Insured affiliated to any other medical interest Yes ☐ No ☐

If YES, please provide details

_____

_____

7.6 Is any telemedicine undertaken by the Insured Yes ☐ No ☐

If YES, please provide details

_____

_____

7.7 Does the Insured undertake staff training Yes ☐ No ☐

If YES, please provide details

_____

_____

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

Financial Year End: _____

Gross Revenue	Last Financial Year	Previous Financial Year	Estimated forthcoming 12 months
Gross revenue of retirement home / frail care			
Gross revenue – rental / leases			
Gross revenue from medical procedures / treatments			
Revenue from other source (please state):			
Total			

9. Staff

Please state number of employees in each of the following classifications

(Should there not be sufficient space – please provide separate sheet)

Name	No. of Employees Full Time	No. of Employees Self Employed / Contracted	No. of Years Practicing
General Practitioner			
Dieticians			
Physiotherapists			
Nursing Personnel			
Nursing Director/s			
Matron/s			
Senior Registered Nurses			
Registered Nurses			
Senior Enrolled Nurses			
Enrolled Nurses			
Auxiliary Nurses – Qualified			
Student Nurses			
Care Workers			
Administrative Personnel			
Other (Please specify)			
Other:			
Other:			
Other:			
Other:			
Other:			
Total	0	0	0

9.1 Are all contracted employees required to maintain and hold appropriate qualifications, licensing, and individual Medical Malpractice Insurance cover Yes ☐ No ☐

9.2 Does the Insured undertake to ensure that trainees carry out their duties under proper supervision Yes ☐ No ☐

10. Facilities

10.1 Are any beds or services available to the community on a charitable basis? Yes ☐ No ☐

If YES, please state percentage

_____

_____

10.2 Number of Beds

	Current Year	Prior Year
Independent Living		
Semi Frail Care		
Intermediate Care		
Frail Care		
Sub-Acute Care		
Alzheimer's / Dementia Care		
Charitable Beds		
Other: Please specify		
Total		

10.3 Average annual bed occupancy. (Calculate by noting the occupancy at any specific day of each month and dividing the aggregate total of 12 months by 12.) _____ **%**

10.4 Age Profile of Residents

	Current Year	Prior Year
Under 50		
50 – 60 years old		
Over 60 years old		
Total		

Section Three – Risk Management and Protocols

11. What protocol management is in place in respect of administering, dispensing and storage of medication? If protocol is documented – please provide copy

_____

_____

_____

11.1 How often is medication reports reviewed and by whom? (e.g. pharmacist etc.)

_____

_____

11.2 Emergency Protocols

11.2.1 Are nursing staff available 24 hours per day Yes ☐ No ☐

11.2.1.1 Please detail: Number of Shifts _____ Hours per Shift _____ Nursing Staff _____

11.2.2	Are nursing staff available 24 hours per day	Yes ☐	No ☐
11.2.3	Is there a doctor on call in respect of emergencies?	Yes ☐	No ☐
11.2.4	Does the facility practice and undertake emergency drills	Yes ☐	No ☐
11.2.5	Does your premises comply with the current fire precaution requirements	Yes ☐	No ☐

11.2.6 If any questions, have been answered as NO, please provide full details

_____

_____

11.2.7 Distance to the closest hospital? _____ kms

11.2.8 Please detail emergency protocols should a resident require emergency medical assistance

_____

_____

_____

11.3 Please detail your fall prevention programme, with attention to the prevention of "slip and trip" falls (handrails, non-slip flooring etc.) If protocol is documented – please provide copy

_____

_____

_____

11.4 Please detail measures taken to prevent elopement and wandering off of patients, in particular to patients with Alzheimer's disease and other such conditions of dementia. If protocol is documented – please provide copy

_____

_____

_____

11.5	Are all buildings owned or used by you in a good state or regularly maintained / repaired	Yes ☐	No ☐

11.6 Are the following regularly checked, serviced, and repaired by fully qualified engineers

Air conditioning units	Yes ☐	No ☐
Electricity generators (including any emergency backup generators)	Yes ☐	No ☐
Escalators	Yes ☐	No ☐
Heating systems and boilers	Yes ☐	No ☐
Hoists	Yes ☐	No ☐
Incinerators	Yes ☐	No ☐
Lifts	Yes ☐	No ☐
Water tanks	Yes ☐	No ☐

11.7 Please provide details any subcontracted functions or facilities

_____

_____

_____

11.8	Do you ensure subcontractors carry their own insurance	Yes ☐	No ☐
11.9	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

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11.10 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

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

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

_____

_____

_____

_____

_____

14. How are your patient records secured?

_____

_____

_____

_____

_____

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

_____

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

_____

_____

_____

_____

_____

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

If YES, please attach full details

18. 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 ☐

19. Limit of Indemnity and Deductible Required

Limit: _____ Deductible: _____

Limit: _____ Deductible: _____

Limit: _____ Deductible: _____

Limit: _____ Deductible: _____

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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