

**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 Registration and Department of Health Registration
- CV and copy of all qualifications (New Applications or change in scope of practice)
- Consent Form (only if the client provides ambulance / paramedical services at Events)
- Patient Report Form
- Proof of previous insurance (if moving from another insurer) (New Applications or change in scope of practice)
- Claims Information (if applicable)
- Annexure A to be completed if services rendered at events
- Example of incident register maintained

**The Proposal form comprises of:**

- Section One**      Your Organisation  
**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.

**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**

Proposers Name \_\_\_\_\_  
ID Number (If sole Trader) \_\_\_\_\_  
Incorporation details (if any) \_\_\_\_\_  
Trading name (if different from the above) \_\_\_\_\_  
Please provide your VAT registration number \_\_\_\_\_  
Company Registration Number \_\_\_\_\_  
Medical Council registration number \_\_\_\_\_  
Practice Number \_\_\_\_\_

Physical Address \_\_\_\_\_ code \_\_\_\_\_  
 Postal Address \_\_\_\_\_ code \_\_\_\_\_  
 Email \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Website \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_

**4. Name and Qualifications of Directors and Key Personnel**

Name	Position Held	Qualifications	Date Qualified

**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. Is the organisation a member of Disaster Risk Management Institute of South Africa (DMISA)? Yes  No
7. Is the organisation a member of Emergency Medicine Society of SA (EMSSA)? Yes  No
8. 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*

**9. Confidential Professional Information / Claims**

- 9.1 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*

- 9.2 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*

- 9.3 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*
- 9.4 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*
- 9.5 Have you or any Principals or Employees 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*

**10. 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**

11. Do you undertake any services of a state-owned facility / government hospital or clinic? Yes  No   
*If yes, please provide full details*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Are you an employee of an institution? Please state name of entity for which you work Yes  No   
*(Applicable to Individuals)*

\_\_\_\_\_

**13. Revenue / Fees (Gross) (Inclusive of VAT)**

Financial Year End:	Last Financial Year	Previous Financial Year	Estimated forthcoming 12 months
Gross revenue from fees			
Gross revenue from other sources			
Total			

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

a) Fully Qualified and Trained Paramedics

Name	HPCSA Registration No	Qualifications	Experience

b) Trainee Paramedics

Name	HPCSA Registration No	Qualifications	Experience

c) Volunteers

Name	HPCSA Registration No	Qualifications	Experience

d) Other Staff

Name	HPCSA Registration No	Qualifications	Experience

15. Staff Count

	Current Year	Prior Year
Principals		
Number of basic ambulance assistants (BAA / ECA'S)		
Number of ambulance emergency assistants (ILS)		
Number of advanced life support medics (ALS)		
Volunteers / Part Time		
Other:		
Total		

16. Ambulances

	Current Year	Prior Year
Number of ambulances in operation		
The minimum qualification for ambulance crew members		
Number of crew members per ambulance per category		
a) Basic Ambulance Assistants		
b) Ambulance Emergency Assistants		
c) Fully trained/ qualified paramedics		
d) Other		

17. Rapid Response Vehicles

	Current Year	Prior Year
Number of rapid response vehicles in operation		
The minimum qualification of rapid response vehicle crew members		

Are all vehicles i.e. Ambulances and rapid response vehicles fully equipped to handle any/all emergencies: Yes  No

NO, please specify:

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Number of crew members per vehicle per category	Current Year	Prior Year
a) Basic Ambulance Assistants		
b) Ambulance Emergency Assistants		
c) Fully trained/ qualified paramedics		
d) Other		

18. Please provide details

	Ambulances	Rapid response vehicles
The approximate number of emergency calls per month		
The approximate number of routine trips to hospital/ inter-hospital transfers per month		
The average approximated radius of operations		

19. Number of shifts and hours worked per shift of crew members (ambulances and rapid response vehicles)

	Number of shifts	Hours per shift
Basic Ambulance Assistants		
Ambulance Emergency Assistants		
Advanced Life Support Staff		
Other : (Specify)		
Other : (Specify)		

20. Is an air ambulance repatriation service maintained Yes  No

Please provide details:

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21. The territories in which you expect to operate

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22. Number of repatriations per annum \_\_\_\_\_

23. Do you undertake any services in respect of event, if yes complete **Annexure A** cover for events is not automatically included if not disclosed Yes  No

**Section Three – Risk Management**

24. Does any staff 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 provide full details*

25. 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 full details*

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

27. What system is in place for capture patient notes?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

28. How are your patient records secured?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

29. How long do you retain patients medical records?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

30. Please detail procedures in place in dealing with patient complaints:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

*Please provide copy of protocol*

**32. 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: \_\_\_\_\_

## 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.

\_\_\_\_\_  
Signature of Proposer

\_\_\_\_\_  
Name of Proposer (print)

Y	Y	Y	Y	M	M	D	D
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Date

\_\_\_\_\_  
Designation