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An Authorised Financial Services Provider: License Number – 31213

MEDICAL MALPRACTICE PROPOSAL FORM FOR DENTISTS

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.

DISCLOSURE

You must disclose to the Insurer all information which is material to it in deciding whether to issue insurance cover to you, including any facts or conduct which might lead to a claim being made against you. Failing to do so could affect your rights to indemnity.

If you do not understand any part of this document, please contact your Broker BEFORE YOU SIGN IT. You will be bound by the answers, which are given, and by the information provided by you in this proposal form. It is in your interest to make sure that all information is correct and properly understood.

When in doubt disclose

ATTACHMENTS

Before you return this form, have you included the following (please indicate by ticking the boxes):

Company brochure/ additional information: ☐

Claims information (if relevant): ☐

Please attach details where not enough space on the proposal

1. **Details of Proposed Insured;**

a. Insured / Practice Name: ______________________________
(Please attach details of all subsidiary companies) ______________________________

b. Postal Address: ______________________________
____
____
____

c. Telephone Number: ______________________________

Fax Number: ______________________________

d. E-Mail address: ______________________________

e. Web Site: ______________________________

f. VAT Registration No: ______________________________

g. Present Legal Constitution (Mark Relevant Box)

Sole Practitioner ☐ Partnership ☐ Incorporated Co. ☐ Limited Co. ☐ Closed Corp. ☐

h. Date of commencement of Practice: As currently constituted: ______________________

As initially established: ______________________

i. Names and Qualifications of Principals.
   I. In case of Partnerships – Partners
   II. In case of Incorporated Companies – Directors
   III. In case of Limited Companies – Professionally qualified Directors and Employees
   IV. In case of Closed Corporations – Members

Name	Qualifications	Date Qualified	How long Principal in this Practice

j. Are any branches of the Proposed Insured located outside of South Africa? Yes ☐ / No ☐

If yes, please provide full details:

____
____

2. Detailed Business Description:

____

____

____

3. Claims experience

a. Have any claims ever been made against the proposed Insured / Partners / Directors / members or Employees for the type of cover for which you are now applying? Yes ☐ / No ☐

If yes, please provide full details:

____

____

b. After enquiry, are any of the Proposed Insured / Partners / Directors / Members or Employees aware of any circumstances which would be covered under a policy of this type, that may result in any claims or any possible claims being made against them? Yes ☐ / No ☐

If yes, please provide full details:

____

c. Please provide the claim numbers for those claims already registered with Insurers.

____

4. Details of Insurance

a. Are you at present or have you in the past been Insured? Yes ☐ / No ☐

If yes, please provide the following details:

Name of Insurers: ____

Date cover expires/d: ____

Expiry of “Run-off” cover (if any): ____

Limit of Liability: ____

Excess applicable: ____

b. For the type of Insurance now being proposed, has any Insurer ever:

I. declined a Proposal or renewal for this Practice or any Partner / Principal? Yes ☐ / No ☐
II. required an increased premium or imposed special terms? Yes ☐ / No ☐
III. cancelled an Insurance? Yes ☐ / No ☐

If yes, please provide full details:

____

____

____

c. Do you require cover in respect of any liability incurred but not discovered prior to the effecting of this insurance at a single premium to be negotiated? Yes / No

5. Qualifications

5.1. At what Medical School/s did you obtain your qualifications?

____

____

5.2. In what year did you qualify? ____

5.3. What degree did you obtain? ____

6. What did you specialise in?

____

____

____

6.1. Where have you practiced your profession since graduation and what year(s)?

Practiced profession	**Year**

7. Details of Partners / Practice

7.1. Names of Partners
(For Insurance purposes, each Partner is required to complete a Proposal form)

____

____

7.2. What is the title of the Practice: ____

____

7.3. Name all other employees of the corporation. (Each qualified employee is required to complete a proposal form, except Technicians and Nurses other than Nurse Anesthetists)

____

____

____

7.4 If you are not the employee of a practice, please provide the following information:

7.4.1 Name all qualified Assistants (each must complete a proposal form)
7.4.2 Names of Nurse Anesthetists (with Qualifications)
7.4.3 Names of other Nurses (with qualifications)

Name	Career Type	Qualifications

7.4.4 Do you require any of your employees to be named Insured's? Yes / No

If yes, please provide full details:

____
(Please attach details if not enough space)

7.5 Are you duly licensed in accordance with law to practice at the address(es) specified in Question 1? Yes / No

7.6 Of which Profession Associates or Societies are you a member in good standing?

____

____
(Please attach details if not enough space)

7.7. Do you advertise you business or profession:

a) other than as permitted by your National or Local Professional Association of Society? Yes / No

b) other than by an entry in the yellow pages giving only your address and telephone number? Yes / No

If yes, please provide full details:

____

____

7.8. Are you GMC (or other National Body) Certified? Yes / No

7.8.1. Are you GMC (or other National Body) eligible? Yes / No

If YES

a) In what speciality? ____

b) When? ____

7.9. Have you or any of your Partners, Assistants, Technicians or Nurses any physical, physiological, emotional, pathologic or psychiatric disability? Yes / No

If yes, please provide full details:

____

____

7.10 Are you in the employ of any individual, firm or group (other than that referred to in above), hospital (of any category) or health facility of any kind? Yes / No

If yes, please provide full details:

____

____

7.11. Are you under contract to any individual, firm or group, hospital (of any category) of health facility of any kind? Yes / No

If yes, please provide full details:

____

7.12 Are you engaged in any additional medical activities for which you receive payment? Yes / No

If yes, please provide full details:

____

____

7.13. Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered? Yes / No

If yes, please provide full details:

____

____

7.14. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offences? Yes / No

If yes, please provide full details:

____

____

8. Revenue

8.1. Please state date of your immediate past Financial Year End : ________________________

8.2. Kindly provide the following details:

	Immediate past Financial Year End	Previous Financial Year End
Gross Revenue of the Hospital / Clinic	**R**	**R**
Gross Revenue relating to Rentals / Leases etc.	**R**	**R**
Gross Revenue from Medical Procedures / Pharmacies or any other Medical Treatment.	**R**	**R**
Gross Revenue from any other source (Give brief details below)	**R**	**R**

9. State any other procedure that you might need cover for (please provide details below):

____

____

N.B. Coverage is afforded only in respect of the procedures listed in (9) above for which a specific premium has been paid and in addition for General Practice. If coverage is required for any other procedures, such procedures must be specifically declared.

10. Fee income (as at the company's financial year end)

Please give the audited fees for the past 5 years:

Year End	Fees
	R
	R
	R

Year End	Fees
	R
	R
Estimate for coming 12 months	R

11. Quotations required

11.1 Limit any one period of insurance inclusive of costs and expenses.

R________________________________

R________________________________

R________________________________

11.2 Deductible (Excess)

(The amount carried by Insured per claim)

R________________________________

R________________________________

R________________________________

11.3 Do you require a quote on one or two reinstatements of the Limit during the period of Insurance? Yes ☐ / No ☐

Declaration:

- I/we declare that after proper enquiry the statements and particulars given above are true and that I/we have not miss-stated or suppressed any material fact.
- I/we agree that this Proposal Form, together with any other material information supplied by me/us shall form the basis of any contract of insurance effected thereon.
- I/we undertake to inform underwriters of any material alteration to these facts occurring before the completion of the contract.

______________________________	______________________________
Signed on behalf of Insured	Full name
______________________________	______________________________
Position held at Insured	Date