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An Authorised Financial Services Provider: License Number – 31213

PROFESSIONAL INDEMNITY - HEALTHCARE PRACTITIONER
PROPOSAL FORM
MEDICAL MALPRACTICE

IMPORTANT NOTICE

This form may be used for New Business or Renewals. In the case of Renewals, the completed form must be received by the Underwriters and acceptance of the renewal terms advised to them prior to renewal date, failing which no cover exists after such date.

Please answer ALL questions fully. Where the space provided is insufficient, a separate sheet should be attached.

1. Details of Proposer:

1.1 Full Name of Proposer: _____

1.2 Identity No.: _____

1.3 Physical Address: _____

1.4 Are you duly licensed in accordance with the law to practice at the above address? _____

1.5 E-mail Address: _____

1.6 Telephone No: _____

1.7 VAT Reg. No: _____

1.8 Medical Council Reg. No: _____

1.9 Date of Commencement of Practice: _____

1.10 Qualifications:

Qualifications	Date Qualified	Name of Educational Establishment

1.11 State the name of any Professional Association/Body that you are a member of:

_____

2. Description of Business/Activities:

2.1 Detailed Business Description:

_____

_____

2.2 Are you a GP or Specialist? _____

If you are a Specialist, please specify what kind:

- ❑ Abdominal Surgeon
- ❑ Cardiologist
- ❑ Cardiovascular Surgeon
- ❑ General Surgeon
- ❑ Neuro Surgeon
- ❑ Obstetrician/Gynaecologist
- ❑ Oncologist
- ❑ Ophthalmologic Physician (excluding surgery)
- ❑ Ophthalmologic Surgeon
- ❑ Othopaedic Surgeon
- ❑ Otorhinolarygologist
- ❑ Pathologist
- ❑ Physician
- ❑ Plastic Surgeon
- ❑ Proctologist
- ❑ Psychiatrist
- ❑ Radiologist or Roentgenologist
- ❑ Thoracic Surgeon
- ❑ Urologist
- ❑ Other Practitioner. Please specify: _____

2.3 State approximate division of your work:

- ❑ Adenoidectomy
- ❑ Administration of general anaesthesia
- ❑ Administration of spinal, caudal or epidural
- ❑ Amputation of digits or limbs
- ❑ Angiographic procedures and cardiac catheterization
- ❑ Assist in surgery on your own patients
- ❑ Biopsy excision of lymph nodes
- ❑ Bronchoscopy
- ❑ Catheterization - arterial, cardiac or diagnostic
- ❑ Circumcision
- ❑ Clinical trials
- ❑ Closed reduction of fractures
- ❑ Culdoscopy
- ❑ Cytoscopy
- ❑ Diagnostic x-ray procedures (other than plain x-ray)
- ❑ Dilation and curettage
- ❑ Exchange transfusions
- ❑ General practice
- ❑ Hypnosis
- ❑ Insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers

- ❑ LASIK operations
- ❑ Mastectomy
- ❑ Mastoidectomy
- ❑ Neuro Surgery
- ❑ Obstetric procedures excluding deliveries
- ❑ Obstetrics including normal deliveries and Caesarean sections
- ❑ Obstetrics including normal deliveries but excluding Caesarean sections
- ❑ Oesophagoscopy
- ❑ Operations on the inner ear
- ❑ Operations on the organs of the neck (other than biopsy excision of lymph nodes)
- ❑ Ophthalmic surgery
- ❑ Orthopaedic operations on the smaller joints
- ❑ Orthopaedic surgery (other than othopaedic operations on the smaller joints)
- ❑ Other types of surgery and operations performed under general anaesthesia
- ❑ Plastic/Cosmetic surgery
- ❑ Plating, pinning open reduction of fractures
- ❑ Prescription or fitting of contact lenses
- ❑ Procedures involving entry surgically or otherwise in the abdomen (other than procedures concerned with normal delivery which may include episiotomy and application of low forceps)
- ❑ Procedures involving entry surgically or otherwise into the spine, thorax or skull
- ❑ Reconstructive vascular surgery and thromboembolectomy of the larger arteries & veins
- ❑ Resection of facila bones and tissues
- ❑ Sigmoidoscopy
- ❑ Surgical or injection treatment of varicose veins
- ❑ Tonsillectomy
- ❑ Traumatic
- ❑ Treatment of mental illness, drug addiction or alcoholism
- ❑ Any other procedure - Please specify: _____

2.4 Are you in the employ of any individual, firm, group, hospital or health facility of any kind? If so, please state the name of your employer: _____

2.5 Are you engaged in any additional medical activities for which you receive payment? Please provide details: _____

2.6 Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered? Please provide details:

_____

3. Fee Income

3.1 Financial year end date: _____

3.2 Fee Income for the past and current financial years and estimate for the coming year:

	Actual for last completed financial year	Estimate for current financial year	Estimate for next financial year
Gross Fee Income			

4. Claims Experience

4.1 Have any complaints or claims ever been made against the Proposer and/or its Employees for the type of cover for which is now being applied for? Yes □ / No □

If Yes, please provide full details:

_____

_____

4.2 After specific enquiry, are the Proposer and/or its Employees aware of any circumstances which would be covered under a policy of this type, or any other policy for the same type of cover, that may result in any claims or any possible claims being made against them?
Yes □ / No □

If yes, please provide full details:

_____

_____

4.3 Please provide full details of corrective measures taken to avoid recurrence of any claims or circumstances.

_____

_____

4.4 Have you ever been struck from the role or suspended? If so, please provide full particulars:

_____

_____

5. Details of Insurance

5.1 Are you at present or have you in the past been insured for this type of cover? 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 Indemnity: _____

Deductible: _____

Retroactive Date: _____

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

a) Declined a proposal or renewal for this Proposer or any of its Employees? Yes □ / No □
b) Required an increased premium or imposed special terms? Yes □ / No □
c) Cancelled a policy of insurance? Yes □ / No □

If Yes, please provide full details: _____

_____

5.3 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 □

6. Quotations Required

6.1 Please indicate what Limits to be quoted on:

R _____ R _____

R _____ R _____

(Note that R 1,000,000 is the minimum Limit)

6.2 Do you require a quote on one or two Reinstatements of the Limit during the period of insurance?

1 Reinstatement Yes □ / No □

2 Reinstatements Yes □ / No □

7. Declaration:

- ❖ I/we declare that after proper enquiry the statements and particulars given above are true and that I/we have not misstated 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.

_____ _____

Signed on behalf of Proposer Full name

_____ _____

Position held at Proposer Date