

# PROPOSAL FORM

## Medical Malpractice

### Individual Healthcare Practitioners



#### 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 / AHPCSA Registration
- CV and copy of all qualifications (New Applications or change in scope of practice)
- Copy of all consent forms used in practice
- Copy / Example of records used in practice (New Applications or change in scope of practice)
- Proof of previous insurance (if moving from another insurer) (New Applications or change in scope of practice)
- Claims Information (if applicable)
- Addendum 1 to be completed in respect of Psychologists and similar professions

#### The Proposal form comprises of:

- Section One** Applicant Details
- Section Two** Scope of Clinical Practice
- 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

#### Section One – Applicants Details

1. **Application Type** New Application  Scheduled Review Application  Additional/Changed Scope of Clinical Practice

2. **Your Organisation**

Full Name \_\_\_\_\_

Date of birth: 00/00/0000 

Y	Y	Y	Y	M	M	D	D
---	---	---	---	---	---	---	---

ID Number \_\_\_\_\_

Incorporation details (if any) \_\_\_\_\_

Trading name (if different from the above) \_\_\_\_\_

Please provide your VAT registration number \_\_\_\_\_

Medical Council registration number \_\_\_\_\_

How long have you been in practice? Current Practice  Years in Practice

Practice number (if applicable) \_\_\_\_\_

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

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

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

Please provide list of Licensing / Registration Body with which you hold a valid licence / membership?

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

Are you a member of any Association? Yes  No

*if Yes, who and for how long?*

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

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

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

4. Please list all your registered qualifications including any post – graduate qualifications, where and when this was obtained

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

5. Confidential Professional Information / Claims

5.1 Have any claims / incidents / circumstances for malpractice been made against you / practice during the past five 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 you had any civil or criminal actions against you, where there was a finding of liability or guilt with respect to your clinical practice? Yes  No

*If YES, please provide full details on a separate page*

5.4 Has a criminal claim of any nature ever been made against you / your practice? Yes  No

*If YES, please provide full details on a separate page*

5.5 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*

- 5.6 Have you 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*
- 5.7 Do you 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 attach full details*
- 5.8 Do you employ Locums to assist you at your practice Yes  No   
*If YES, kindly ensure that all Locums have their own Professional Indemnity / Medical Malpractice Policy in place, as their activities will not be covered in terms of your Policy*
- 5.9 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*
- 5.10 Is there any additional information that may have significance, when we assess your individual risk, for example full time Hospital employment, academic involvement, registrar, etc

---



---



---

**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 – Scope of Clinical Practice**

7. Do you undertake any services in a state-owned facility / government hospital or clinic? Yes  No

8. Are you an employee of an institution? Please state name of entity for which you work. Yes  No   
 \_\_\_\_\_

9. Do you undertake any locum work? If yes, please detail locum work Yes  No   
 \_\_\_\_\_

10. If a practice, please provide list of all staff in the practice

Name	Position	Qualification	Part Time / Full Time

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

Financial Year End:	Last Financial Year	Previous Financial Year	Estimated forthcoming 12 months
Gross revenue from private practice			
Gross revenue from state institutions			
Gross fees excluding VAT			
Gross revenue from other sources			
Total			

**12. Patients**

- a. In the last 12 months, how many patients have you consulted with (actual) \_\_\_\_\_
- b. Expected number of patients in the next 12 months \_\_\_\_\_
- c. Total number of treatments / sessions / consultations in the last 12 months (actual) \_\_\_\_\_
- d. Expected number of treatments / sessions / consultations in the next 12 months \_\_\_\_\_

**13. In what AREA or branches of HEALTHCARE are you qualified and, if applicable, licensed to practice**

Acupuncture		Aromatherapist	
Audiologist/speech therapist		Biokineticist	
Chinese medicine		Chiropractor	
Cytologist		Dermatologist	
Dietician		Homeopathy	
Haematologist		Medical technologist	
Natureopathy		Medical Lab Technician	
Nutritionist		Optometrist	
Orthotist/prosthetist		Occupational therapist	
Osteopathy		Pathologist	
Physiotherapist		Podiatrist	
Psychiatrist		Psychologist	
Prosthetist/Orthotist		Radiographer	
Radiologist		Reflexologist	
Sexologist		Sports scientist	
Other:		Other:	

**14. Additional Information**

- 14.1 What equipment if any is being used to perform treatments  
\_\_\_\_\_
- 14.2 What is the age group breakdown of the patients you provide treatment to  
\_\_\_\_\_
- 14.3 Do you prescribe and/or supply any products (including medicines, creams etc.) Yes  No

If yes, please provide :

Product	Use (Internal / External)	Supplier / Producer	Approx. Fees

**Section Three – Risk Management**

**15. Risk Management**

15.1 Is it Mandatory that all your patients sign a consent form for consultations? Yes  No

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

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

15.4 How are your patient records secured?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15.5 How long do you retain patients’ medical records?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15.6 Please detail procedures in place in dealing with patient complaints  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15.7 Do you have an internal risk management protocol? Please provide copy of protocol Yes  No

**16. 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
---	---	---	---	---	---	---	---

Date

\_\_\_\_\_  
Designation