PROPOSAL FORM

Medical Malpractice Allied Healthcare

Hollard.

Underwritten by The Hollard Insurance Co. Ltd, an authorised Financial Services Provider

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ITOO is an Authorised Financial Services Provider. FSP No. 47230

Please answer **ALL** questions completely
Should any question or part thereof not be applicable, please state "N/A"
Should insufficient space be provided, please continue on your company letterhead

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

1. Name of Insured ______________________________

2. Has the Insured ever carried out medical services under a different name | Yes | | No | |

   *If **YES**, please provide details*

3. Head office physical and postal address ______________________________

4. Location of branch offices ______________________________

   ____

5. Telephone Number ______________________________

6. Email Address ______________________________

7. Does the Insured have any subsidiary companies that you require cover for | Yes | | No | |

   *If **YES**, please provide details*

8. VAT Number ______________________________

9. Company Registration Number ______________________________

10. HPCSA Number ______________________________

11. Which associations, professional bodies or self-regulatory organisations is the Insured a member of or registered with

12. Please give a full description of the Insured's business activities for which cover is required

13. Revenue

a. Total gross annual income excluding income from the sale of goods

b. Total gross annual income from any work for the state

a.	
b.	

14. In what AREA or branches of ALLIED HEALTHCARE medicine are you qualified and, if applicable, licensed to practice

	Percentage of total work	
Work	**Private Practice**	**State Facility**
Acupuncture		
Aromatherapist		
Audiologist/Speech Therapist		
Biokinenticist		
Chinese Medicine		
Chiropractice		
Cytologist		
Dental Therapist		
Dietician		
Homeopathy		
Medical Physicist		
Medical Technologist		
Natureopathy		
Nurse		
Nurse (Path Lab/Wound Care)		
Midwife/Doula/Lactation		
Occupational Therapist		
Optometrist		
Oral Hygienist/Dental Therapy		
Orthotist/Prosthetist		
Osteopathy		
Paramedic/Medic		
Ambulance Operator		
Podiatrist		
Psychologist		
Radiographer		

Reflexologist		
Sexologist		
Sports Scientist		
Other:		

15. Please provide full details of all qualifications and courses that you have undertaken, on the above branches of medicine and include dates of qualification, and how long you have been practicing in these fields

16. If you are an Employee, please state the name of the company (or other entity) for whom you work

17. Are patient records kept, where and how long are they retained

18. Do you own (wholly or partly), operate or administer any hospital, nursing home or any other medical establishment

Yes		No	

*If **YES**, an additional proposal form will have to be completed before quotations can be given*

19. Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e. Hepatitis, HIV, Epilepsy etc. or other impediment which may affect the performance of his/her professional duties or place patients/clients at risk

Yes		No	

*If **YES**, what risk management procedures are in place*

20. Has the Proposer or any employee involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries

Yes		No	

*If **YES**, please provide details*

21. Is it a condition of your employment that you maintain Medical Malpractice Insurance **Yes** ☐ **No** ☐

*If **YES**, please provide details*

22. Have you ever been insured for Medical Malpractice **Yes** ☐ **No** ☐

*If **YES**, please provide details*

23. Please complete for each member of staff to be covered on a separate sheet: (not applicable to Sole Practitioners)

Name	Qualification	Date qualified	Full Time/Part Time

GENERAL INFORMATION

24. List all 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 or employees, whether insured or not, in the past 5 years

25. 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 details*

26. 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 details*

LIMIT OF INDEMNITY

Quote request	

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 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.

Name (duly authorised)

Designation

Signature

D	D	M	M	Y	Y	Y	Y

Date