PROPOSAL FORM

Medical Malpractice Ambulance Services

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. Company Resitration Number ______________________________

9. VAT Number ______________________________

10. HPCSA Number ______________________________

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

12. Please state personnel details

Name	Position	Qualifications	Date Qualified

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

Which body	Period of membership

14. Has any membership or registration with such organisation/body ever been suspended, withdrawn, amended, declined or had any specific conditions attached

Yes		No	

Which body	Period of membership

15. Are accurate and descriptive records of all medical services and procedures kept

Yes		No	

16. How are they stored, where and for how long

17. Fully qualified and trained Paramedics
    a. Number of basic ambulance assistants (BAA / ECA'S)
    b. Number of ambulance emergency assistants (ILS)
    c. Number of advanced life support medics (ALS)

18. Ambulances
    a. Number of ambulances in operation
    b. Are these ambulances all fully equipped to handle any/all emergencies — Yes / No
    c. Number of crew members per ambulance per category
        - Basic Ambulance Assistants
        - Ambulance Emergency Assistants
        - Fully trained/ qualified paramedics
    d. Number of rapid response vehicles in operation
    e. Minimum qualification of rapid response vehicle crew members

19. 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		

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

Position	Number of Shifts	Hours per Shift
Basic Ambulance Assistants		
Ambulance Emergency Assistants		
Advanced Life Support Staff		

21. Is an air ambulance repatriation service maintained — Yes / No

Please provide details

22. The territories in which you expect to operate

23. Number of repatriations per annum

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

Yes		No	

What procedures are in place to manage the risk

25. Has the Insured 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	

What procedures are in place to manage the risk

26. Revenue

a. When is your financial year end	
b. What was your income for the past 12 months	
c. What is your estimated years fees for the forthcoming 12 months	

GENERAL INFORMATION

27. 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

28. 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*

29. 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