In association with Hollard.

PROPOSAL FORM
Medical Malpractice General Practitioners

Hollard.

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

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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

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. Registration Number _____

10. Please state the partner(s) names and details of their experience and qualifications

Name	Shareholding (%)	Experience/Qualifications	HPCSA Number

11. How long have you been in practice

a. Current practice		b. Total years in practice	

12. List all professional organisations or registered self-regulating bodies of which you are a member

13. List your registered qualifications and name the medical school you attended

14. List any particular branch of medicine you specialise in

15. State your registered post graduate qualifications and state where they were obtained

16. State whether you practice as a

Physician		**Pathologist**	
Oncologist		**Cardiologist**	
Psychiatrist		**Radiologist/ Roentenologist**	
General Surgeon		**Plastic Surgeon**	
Orthopaedic Surgeon		**Urologist**	
Thoracic Surgeon		**Neuro Surgeon**	
Cardio Vascular Surgeon		**Otorhinolaryngologist**	
Proctologist		**Ophthalmologic Surgeon**	
Ophthalmologic Physician (excluding surgery)		**Obstetrician and Gynaecologist**	
Physician and Non-Specialist Surgeon		**Other**	

17. State approximate division of your work and indicate if you require coverage for the following

	Percentage of total work	
Work	**Private Practice**	**State Facility**
The prescription or fitting of Contact Lenses		
Hypnosis		
The treatment of mental illness, drug addiction or alcoholism		
Diagnostic X-Ray procedures (other than plain X-Ray)		
Angiographic procedures and Cardiac Catheterization		
Administration of spinal, caudal, epidural or general anaesthesia		
Plastic Surgery (other than minor skin grafts)		
• Traumatic		
• Cosmetic		
Major surgery such as:		
• Orthopaedic Surgery (other than orthopaedic operations on the smaller joints)		
• Neuro-Surgery		
• Amputation of Limbs		
• Plating, pinning open reduction of fractures		
• Procedures involving entry surgically or otherwise into the spine, thorax or skull		
• 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)		
• Mastectomy		
• Resection of facila bones and tissues		
• Operations of the organs of the neck (other than biopsy excision of lymph nodes)		
• Reconstructive vascular surgery and thromboembolectomy of the larger arteries and veins		
• Ophthalmic Surgery		
• Mastoidectomy		
• Operations on the inner ear		
• Esophagoscopy		
• Exchange Transfusions		
Intermediate Surgery such as:		
• Tonsillectomy		

• Adenoidectomy		
• Closed reduction of fractures		
• Surgical or injection treatment of varicose veins		
• Orthopedic operations on the smaller joints		
• Amputation of digits		
• Dilation and curettage		
• Culdoscopy		
• Cystoscopy		
• Gastroscopy		
• Sigmoidoscopy		
• Bronchoscopy		
• Biopsy excision of lymph nodes		
• Circumcision		
General Practice which in no circumstances include any of the procedures above		
Any other procedure (please describe)		

18. Does any person involved in the treatment and care of any patient/client suffer from any physical, physiological, pathologic or psychiatric disability

Yes		No	

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

19. Are you employed by any individual, firm or group (other than that referred to above), hospital or any category of health facility of any kind

Yes		No	

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

20. Are you under contract to any individual, firm or group (other than that referred to above), hospital or any category of health facility of any kind

Yes		No	

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

21. Are you engaged in any additional medical activities for which you receive payment | Yes | | No | |

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

22. 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 details*

23. 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*

24. Have you and/or any of your partners and/or employees ever been convicted for an act committed in violation of any law or ordinance other than traffic offences | Yes | | No | |

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

25. Have you ever been the subject of a disciplinary proceeding or reprimand by any administrative body or a professional association | Yes | | No | |

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

26. When is your financial year end

	Last Financial Year End	Previous Financial Year End
Gross revenue from private practice		
Gross revenue from state institutions		
Gross fees including VAT		
Gross revenue from other sources		
Specify:		
Total		

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

_____ D D M M Y Y Y Y

Signature Date