PI / Medical Malpractice Application Nurses/Other

The completion of this proposal does not bind the proposer or company to complete a contract of insurance.

Please state your title, full first name[s] and surname:

.....

Tel. and Fax: ..... ID: .....

Date of birth: ..... Medical Council registration number: .....

Physical or Postal address: .....

.....

E-mail address: .....How long have you been in practice: .....

Please list your registered qualifications and name the medical school you attended:

.....

.....

Please provide your VAT registration number: .....

Are you a member of any professional organization or registered with any self-regulating body? If so state which.

.....

Please state your registered post-graduate qualifications, where and when this was obtained.

.....

Please indicate the following:

- ☐ Phlebotomist
- ☐ Student
- ☐ Care Worker
- ☐ Auxiliary Nurse
- ☐ Enrolled Nurse
- ☐ Qualified Nurse
- ☐ Obstetric procedures e.g. Sonar's amniocentesis, CVS tests excluding deliveries.
- ☐ Obstetrics including normal deliveries but excluding Caesarean sections.
- ☐ Obstetrics including normal deliveries and Caesarean sections.
- ☐ Midwifery duties

Cosmetic procedures, please specify:

.....

If an employee please give the name of employer / facility :

.....

Do your partners carry their own malpractice Insurance? If so, state with whom.

.....

Please state the earliest date [month and year] of continuous and unbroken indemnity society membership or medical malpractice insurance cover to date of this application. Please attach supporting documentation e.g. your latest certificates. We require this information for purposes of assessing your date of retroactive cover.

.....

Within the last five [5] years, have any claims been made against you or your partners in respect of malpractice, or are you aware of any circumstances which may result in such a claim being made? If yes, please provide full particulars on a separate page. .....

Within the last five [5] years, have you or your partners been struck off the roll or suspended? If yes, please provide full particulars on a separate page.

.....

Is there any additional information that may have significance, when we assess your individual risk, for example full time Hospital employment, academic involvement, registrar, part time private practice, etc.

.....

If you work at a Hospital kindly advise whether you provide service as an:

Independent contractor: ☐ Employee of the Hospital: ☐ Agency worker: ☐

Do you require Top-Up Cover? [Additional premium will be charged] ..... [Not applicable to nurses with midwifery duties]

This application form is issued and processed by **Accu-Prof Brokers**. **Accu-Prof** is an authorized financial service provider, registered with the Financial Service Board **[FSP nr. 32066].** All claims have to be submitted to **Accu-Prof** immediately upon learning thereof. For more information on **Accu-Prof** please visit www.accuprof.co.za or phone 012-345 5015. In exchange for brokering services **Accu-Prof** receives commission from the Insurer. The exact is disclosed in the master **Policy Wording** and is available on request.

You have not received individual advice on this product and is there is anything in the application form or about the product that you do not understand, you should contact **Accu-Prof** to assist you. Advice is provided by any party or person other than an accredited **Accu-Prof** representative may not be relied on and **Accu-Prof** does not accept responsibility for advice provided by an unregistered person. You have to ensure that you understand the form, that you complete it correctly and not withhold any information as this may lead to repudiation of claims. You also have to ensure that the product applies to you and that you need it. You should make certain that you can afford the premiums. You will be issued with a certificate of insurance, which you must study and keep in a safe place.

The Declaration must be signed by the Proposer only

IMPOTANT: It is necessary for you to inform us of all the facts which are likely to influence us in acceptance or assessment of you indemnity. Failure to do so could invalidate this indemnity. If you are in doubt whether any facts may influence us, you should disclose it. I declare that to the best of my knowledge or belief, the statements and particulars given in this proposal are true and complete and that no material facts that are likely to influence the acceptance and assessment of this proposal have been withheld. [If you are in any doubt whether a fact is material, you should disclose it].

I agree to inform the insurer of any change in my material fact.

I also declare that if any information on this proposal has been written by another person on my behalf, that, that person acted as my agent for that purpose.

I agree that this proposal and declaration shall be the basis of the contract between myself and the Insurance Company the will accept the risk.

Name of Proposer [print]: .....

Signature of the Proposer: .....

Date: .....

No cover is in force until the Insurance Company has accepted the proposal and the premium paid, except if provided by an official covering note issued by the Insurance Company