iTOO™

In association with Hollard.

PROPOSAL FORM

Medical Malpractice Pharmacists/ Pharmacies

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

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. HPCSA Number _____

ACTIVITIES OF PHARMACY

11. Please state the discipline(s) in which the Insured is engaged

12. Please state the owner(s) names and details of their experience and qualifications

Name	Shareholding (%)	Experience/Qualifications

13. Are any of the above shares held by US interests

Yes		No	

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

14. Pharmacist details

Name	Qualification	Date Qualified	Pharmacy Council Number

15. Please state the number of

Pharmacists, Excluding Principals/Owners		Locums	
Nurses/Pharmacy Clinic Sisters		Pharmacy Assistants/Interns/ Students	
Other Staff (Assistants, Admin, Drivers, Cleaning)		Industrial Management	
Retail/State Principal		Retail/State/Industrial Employee	
Other (e.g. Wholesalers, Regulatory Affairs		Other:	

16. Are you a Pharmaceutical Society Member (PSSA) **Yes** ☐ **No** ☐

*If **YES**, please provide membership no.*

17. Are you a member of any other Pharmaceutical Association/Society, if so, indicate which Association/Society **Yes** ☐ **No** ☐

*If **YES**, please provide membership no.*

18. Has membership or registration with such Association/Society ever been suspended, withdrawn, amended or declined or had any special conditions attached **Yes** ☐ **No** ☐

*If **YES**, please provide full information*

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

20. Has the Institution been issued with the necessary licence by the Local Authority, enabling it to trade legally at the premises **Yes** ☐ **No** ☐

21. Revenue

a. When is your financial year end

b. Last year's total gross annual income including income from the sale of goods

c. Estimated total gross annual income including income from the sale of goods

GENERAL INFORMATION

22. 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

23. 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*

24. 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, canceled 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 _____ Date D D M M Y Y Y Y