FSP No. 13147
VAT # 42601 08016
Reg. # 1962/004355/07
Lloyds: 106587 OFW
Medical Accreditation: ORG 752

PROFESSIONAL INDEMNITY PROPOSAL FORM

Part 1 – General Information

The proposal must be completed and signed by the Insured. This proposal is a quotation request and shall form the basis of the insurance contract between the Insured and the Insurer, on acceptance thereof by both parties. Making any false statements or withholding any material fact may give the Insurer the right to repudiate any claim made under the policy or may result in the policy being declared null and void from inception, as the case may be. A material fact is any fact that might influence the acceptance of the risk.

1. Inception Date: D D M M Y Y Y Y Broker:

Name of Insured:

Name of Insured Practice:

Contact Person: Contact No:

Postal Address:

Registered Address:

Identity Number: Registration No:

Telephone Number: Fax Number:

Email Address: Website: www

Date established: D D M M Y Y Y Y

PRESENT LEGAL CONSTITUTION

(please mark the box with an (x))

Close Corporation ☐ Limited Co. ☐ Partnership ☐ Sole Practitioner ☐ Incorporated Co. ☐

2. Date of Commencement of Practice:

2.1 As currently constituted 2.2. As Initially established

3. Disciplines(s) in which engaged

4. Names & Qualifications of Directors

Name	Qualification	Date Qualified	How long in practice

4.1 Number of other employees:

5. Finance Details

Please *state your total fee income / commission (including fees paid to sub contractors and consultants)*

Previous year:	R	Estimated for this year:	R

5.1 Indemnity Limit required	R	
5.2 Excess	R	
5.3 Retroactive Date	R	
5.4 Reinstatement of Sum Insured	YES ☐	NO ☐
5.5 Dishonesty of Staff:	YES ☐	NO ☐
5.6 Libel and Slander:	YES ☐	NO ☐
5.7 Loss of Documents:	YES ☐	NO ☐
5.8 Computer Crime:	YES ☐	NO ☐

6. Claims History

6.1 Has the company had any claims in the past five years? If "yes", please give details.

6.2 Has the company ever been declined Professional Indemnity / Fidelity Guarantee Insurance? If "yes" please specify:

6.3 Is any partner or director of principal aware, after inquiry, of any circumstances, which may result in any claim, being made against the firm, their predecessors in business or any of the present or past partners or directors of principal? If "yes" please specify:

6.4 Are you at present or have you in the past been insured? If "yes" please specify:

6.5 Is Indemnity to apply to any Principal who has left / retired / died? If "yes" please specify:

Name	Qualification	Date Qualified	How long in practice

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Part 2 – Malpractice Liability Practitioners

1. At what Medical School did you obtain your Qualifications?

2. In what year did you qualify?

3. What degree did you obtain?

4. State whether you practice as a?

(Answer for each speciality)

a)	Physician	YES ☐	NO ☐
b)	Pathologist	YES ☐	NO ☐
c)	Oncologist	YES ☐	NO ☐
d)	Cardiologist	YES ☐	NO ☐
e)	Psychiatrist	YES ☐	NO ☐
f)	Radiologist or Roentgenologist	YES ☐	NO ☐
g)	General Surgeon	YES ☐	NO ☐
h)	Plastic Surgeon	YES ☐	NO ☐
i)	Prrthlopeadic Surgeon	YES ☐	NO ☐
j)	Urologist	YES ☐	NO ☐
k)	Abdominal Surgeon	YES ☐	NO ☐
l)	Thoracic Surgeon	YES ☐	NO ☐
m)	Neuro-Surgeon	YES ☐	NO ☐
n)	Cardio-Vascular Surgeon	YES ☐	NO ☐
o)	Otorhinolaryngologist	YES ☐	NO ☐
p)	Proctologist	YES ☐	NO ☐
q)	Ophthalmologic Physician (excluding surgery)	YES ☐	NO ☐
r)	Obstetrician & Gynaecologist	YES ☐	NO ☐
s)	Physician and non- specialist surgeon	YES ☐	NO ☐
t)	Physician and non-specialist surgeon	YES ☐	NO ☐
u)	Other Practitioner *(Describe in Full)*	YES ☐	NO ☐

5. a) Name of Partners

(For insurance purposes each Partner is required to complete a Proposal Form)

b) If you are the employee of a practice:

(i) What is its title?

(ii) Name all other employees of the corporation

(Each qualified employee is required to complete a proposal form but proposals are not required for Technicians and Nurses other than Nurse Anaesthetists – Please attach a sheet if required).

c) If you are not the employee of a practice, please:

(i) Name all qualified Assistants (each must complete a proposal form.)

(ii) Names of Nurses Anaesthetists (with qualifications)

(iii) Names of Other Nurses (with qualifications)

Name	Career Type	Qualifications

d) Do you require any of your employees to be named Insured's? YES ☐ NO ☐

If "Yes", please give details.

6. Where have you practised your profession since graduation and what year(s)?

Practised Profession	Year (s)

7. Are you duly licensed in accordance with law to practice at the address (es) specified in Question 2, (Part 1 – General Information)? YES ☐ NO ☐

8. What Professional Associations or Societies are you a member in good standing?

9. Do you advertise your business or profession?

a) Other than as permitted by your National or Local Professional Association or Society? YES ☐ NO ☐

b) Other than by entry in the yellow pages giving only your address and telephone number? If "Yes", please give details YES ☐ NO ☐

10. a) Are you GMC (or other National Body) Certified? If "Yes", YES ☐ NO ☐

(i) In what speciality _____ ii) When? _____

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

	Work	Percentage of Total Work Performed		
9.1	The prescription or fitting of Contact Lenses.	%	YES ☐	NO ☐
9.2	Hypnosis	%	YES ☐	NO ☐
9.3	The treatment of mental illness, drug addition or alcoholism	%	YES ☐	NO ☐
9.4.1	Diagnostic X-Ray procedures (other than plain X-Ray)	%	YES ☐	NO ☐
9.4.2	Angiographic procedures and Cardiac Catheterisation	%	YES ☐	NO ☐
9.4.3	Administration of spinal, caudal, epidural or general anaesthesia.	%	YES ☐	NO ☐
9.5.1	Plastic Surgery (*other than minor skin grafts)*	%	YES ☐	NO ☐
9.5.2	Traumatic	%	YES ☐	NO ☐
9.5.6	Cosmetic	%	YES ☐	NO ☐
9.6	Major Surgery, which shall be defined as:			
9.6.1	Orthopaedic Surgery *(other than orthopaedic operations on the smaller joints)*	%	YES ☐	NO ☐
9.6.2	Neuro-Surgery	%	YES ☐	NO ☐

	Work	Percentage of Total Work Performed				
9.6.3	Amputation of Limbs	%	YES	☐	NO	☐
9.6.4	Plating, pinning open reduction of fractures	%	YES	☐	NO	☐
9.6.5	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)*	%	YES	☐	NO	☐
9.5.6	Mastectomy	%	YES	☐	NO	☐
9.5.7	Resection of facial bones and tissues.	%	YES	☐	NO	☐
9.5.8	Operation on the organs of the neck *(other than biopsy excision of lymph nodes)*	%	YES	☐	NO	☐
9.5.9	Reconstructive vascular surgery and thromboembolectomy of the larger arteries and veins	%	YES	☐	NO	☐
9.5.10	Ophthalmic Surgery	%	YES	☐	NO	☐
9.5.11	Mastoidectomy	%	YES	☐	NO	☐
9.5.12	Operations on the inner ear	%	YES	☐	NO	☐
9.5.13	Oesophagoscopy	%	YES	☐	NO	☐
9.5.14	Exchange Transfusions	%	YES	☐	NO	☐
9.6	Intermediate Surgery which shall be defined as:					
9.6.1	Tonsillectomy	%	YES	☐	NO	☐
9.6.2	Adenoidectomy	%	YES	☐	NO	☐
9.6.3	Closed reduction of fractures	%	YES	☐	NO	☐
9.6.4	Surgical or injection treatment of varicose veins	%	YES	☐	NO	☐
9.6.5	Orthopaedic operations on the smaller joints	%	YES	☐	NO	☐
9.6.6	Amputation of digits	%	YES	☐	NO	☐
9.6.7	Dilation and curettage	%	YES	☐	NO	☐
9.6.8	Culdoscopy	%	YES	☐	NO	☐
9.6.9	Cytoscopy	%	YES	☐	NO	☐
9.6.10	Gastroscopy	%	YES	☐	NO	☐
9.6.11	Sigmoidoscopy	%	YES	☐	NO	☐
9.6.12	Biopsy excision of lymph nodes	%	YES	☐	NO	☐
9.6.13	Circumcision	%	YES	☐	NO	☐
9.7	General Practice which in no circumstances includes any of the procedures in 9.6 above.	%	YES	☐	NO	☐
9.8	Any other procedure *(please describe)*	%	YES	☐	NO	☐
		%	YES	☐	NO	☐
		%	YES	☐	NO	☐

N.B. Coverage is afforded only in respect of the procedures listed in 9.6 above for which a specific premium has been paid and in addition for General Practice. If coverage is required for any other procedures, such procedures must be specifically declared.

12. Have you or any of your Partners, Assistants, and Technicians or Nurses any physical, physiological, emotional, pathologic or psychiatric disability? If "Yes", please give details. YES ☐ NO ☐

13. Are you in the employ of any individual, firm or group (other than that referred to in above), hospital of any category) or health facility of any kind? If "Yes", please give details. YES ☐ NO ☐

14. Are you under contract to any individual, firm or group, hospital (of any category) or health facility of any kind? If "Yes", please give details. YES ☐ NO ☐

15. Are you engaged in any additional medical activities for which your receive payment? If "Yes", please give details. YES ☐ NO ☐

16. Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered? If "Yes", please give details. YES ☐ NO ☐

17. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offences? If "Yes", please give details. YES ☐ NO ☐

18. Have you ever been the subject of disciplinary proceedings or reprimand by an administrative body or a professional association? If "Yes", please give details. YES ☐ NO ☐

19. Please state amount of insurance required (Maximum R2 000 000) inclusive if costs and expenses. R _____ Any one patient

20. Fee Income

(This question must be completed accurately as the figures are used for rating purposes)

a) Please give gross fees received during the past five years:

Year	Gross Fees	Year	Gross Fees
200( )	R	200( )	R
200( )	R	200( )	R
200( )	R	200( )	R

b) Please give the estimated fees for the coming 12 months. R _____

Declaration
I/We hereby declare that the above statements and particulars contained in this Proposal are true and complete. I/We confirm that we have not misled or misinformed underwriters of any material facts, and agree that this proposal form shall be the basis of the insurance contract.

Name:		Date	D D M M Y Y Y Y
Title/Position:		Signature	