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

# HEALTHCARE PROFESSIONALS PROPOSAL FOR MALPRACTICE / PROFESSIONAL INDEMNITY INSURANCE

***SIGNING OF THIS PROPOSAL FORM DOES NOT BIND THE PROPOSER OR UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE.***

## PERSONAL DETAILS

Please complete the following:

Surname: _____Full first names:_____

ID No: _____

Address: POSTAL: _____

_____CODE: _____

PHYSICAL: _____

_____CODE: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

PRACTICE PHONE No: _____FAX No: _____HOME: _____

VAT NUMBER: _____ HPCSA No: _____

DATE OF FIRST REGISTRATION: _____

ARE THERE NOW OR HAVE THERE EVER BEEN ANY CONDITIONS ATTACHED TO YOUR REGISTRATION? _____

HAS THERE EVER BEEN ANY INTERRUPTION IN YOUR REGISTRATION? _____

## PROFESSIONAL DETAILS:

PLEASE LIST YOUR QUALIFICATIONS, UNIVERSITY/COLLEGE ATTENDED AND YEAR OBTAINED:
(Medical / Paramedical only)

DEGREE 1: _____UNIV/COLLEGE: _____YEAR: _____

DEGREE/dipl 2: _____UNIV/COLLEGE: _____YEAR: _____

DEGREE/dipl 3: _____UNIV/COLLEGE: _____YEAR: _____

DEGREE/dipl 4: _____UNIV/COLLEGE: _____YEAR: _____

IN WHAT BRANCH OR BRANCHES OF MEDICINE ARE YOU QUALIFIED AND LICENSED TO PRACTISE?

| | | | |
|---|---|---|---|
| Anaesthesiology | ☐ | Ophthalmology | ☐ |
| Cardiology | ☐ | Orthopaedics | ☐ |
| Community Medicine | ☐ | Orthodontics | ☐ |
| Dermatology | ☐ | Otorhinolaryngology | ☐ |
| Dentistry | ☐ | Paediatrics | ☐ |
| Endocrinology | ☐ | Pathology | ☐ |
| General Practice | ☐ | Pharmacology | ☐ |
| Genetics | ☐ | Physiology | ☐ |
| Haematology | ☐ | Psychiatry | ☐ |
| Immunology | ☐ | Radio Therapeutics | ☐ |
| Industrial Health | ☐ | Rehabilitation | ☐ |
| Neurology | ☐ | Surgery | ☐ |
| Nuclear Medicine | ☐ | Tropical Medicine | ☐ |
| Nutrition | ☐ | Venereology | ☐ |
| Obstetrics/Gynaecology | ☐ | | |
| Other: Please specify | ☐ _____ | | |

ARE YOU INVOLVED IN CLINICAL TRIALS FOR WHICH YOU REQUIRE COVER: Yes/No:_____

AREA OF SPECIALITY: _____ ANY FORM OF SURGERY (Yes/No) _____
(if yes, please provide details)

ANY FORM OF PLASTIC SURGERY OR COSMETIC WORK: _____

IF GENERAL PRACTITIONER: Do you perform any of the following? (*Unless bona fide emergency*).
(Give a separate covering note to your application if detail required)

Surgical procedures other than minor skin procedures, lancing, suturing and circumcision: (Yes/No)

_____

**TOTAL GROSS ANNUAL INCOME:** _____

**PREVIOUS INSURANCE AND CLAIMS DETAILS:**

Are you currently covered for malpractice insurance by an insurance company or friendly society? (Yes/No)
_____

Who is your current insurer/society? _____

Have you ever been refused this type of insurance or asked to leave this type of insurance or organization?
Yes/No)_____

Have you had a disciplinary enquiry or claim made against you in the last 10 years? Yes/No)_____
(If yes, please supply a brief summary on a separate sheet)

If so, have you notified or has your previous/current insurer been notified? Yes/No)_____
(Again, please supply a brief summary on a separate sheet)

Are you currently in a partnership? (Yes/No)_____
If yes, do your partners carry this kind of cover? (Yes/No)_____

Do you require retroactive/backdated cover? (Up to 3 years subject to declaration.) (Yes/No)_____

**LEVEL OF COVER REQUIRED:**

| **PLEASE CIRCLE REQUIRED AMOUNT** | **R10, 000,000.00** | **R20, 000,000.00** | **R30, 000,000.00** |
|---|---|---|---|

**DECLARATION:**

Claims made policy covers claims or suits arising from the provision of/or failure to provide professional healthcare services after the retroactive date on the policy and first brought to your attention while the policy is in force.

Run-off cover is provided for up to 3 years post 'ceasing to practice' or 'retirement' subject to policy conditions and thereafter on application.

**I/We declare and warrant that after enquiry all statements and particulars contained in this proposal and any attachments or addenda are true and that no information whatever has been withheld which may increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as possible. I/We understand that failure to disclose any material facts, which would be likely to influence the acceptance and assessment of the proposal, may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this declaration shall be the basis of the contract between both parties if entered into.**

**Full Name of Proposer:** _____

**SIGNATURE:** _____ **DATE:** _____

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