MEDICAL MALPRACTICE PROPOSAL FORM

For General Practitioners

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

PLEASE READ THESE GUIDANCE NOTES BEFORE COMPLETING THE PROPOSAL FORM.

PLEASE NOTE This Proposal Form is for a CLAIMS MADE policy. A CLAIMS MADE policy only responds to "claims" made against the Insured and notified to Underwriters during the period of insurance.

- Please answer every question fully, and state "NIL", "N/A" or "NONE" as applicable.
- Please complete separate Proposal Forms for each Partner to be included in the quotation and attach a list of all Partners.
- Please submit any additional information you feel may be of assistance to Underwriters, such as Brochures etc.
- It is the duty of the Proposer to disclose all material facts to Underwriters. Where this is omitted, the Underwriters may avoid their obligation under the Policy.
  For the purposes of the Proposal and for all purposes relating to any policy issued pursuant to this Proposal, a 'material fact' shall be deemed to be one that would be likely to influence an Underwriter's judgment and acceptance of your Proposal.

  If you have any further questions or need assistance on completing this form, please contact us on the following details:

INTERMEDIARY DETAILS

Broker: **ALPHABELLE (PTY) LTD**	Broker FSP number: **46984**
Consultant's name: **VANESSA GOUS**	Telephone number: **082 446 9876**
E-mail address: vanessa@alphabelle.co.za	

A. PERSONAL DETAILS

1. Name(s) & Surname _____ Title(s) **DR** _____
2. Gender _____ ID Number _____
3. Cell No. _____ Email Address _____
4. VAT No. _____ HPCSA Reg no. _____
5. Practice No. _____ How long have you been practising? _____
6. Practice Address _____

   Suburb _____

   City _____ Province _____

B. PREVIOUS INSURANCE COVER

Professional Indemnity (PI) cover

1. Have you had previous insurance cover for the type of insurance now being proposed? Yes ☐ / No ☐

   If yes, please provide details of this cover in chronological order in the section below.

Insurer	Start date	End date	Type of cover – Claims-made (CM) or Occurrence-based (OB)	If CM, please indicate original date of cover	Limit of insurance

2. What is your current premium per annum for PI cover? R_____
3. Please provide a copy of your current PI schedule (mandatory if requesting Retroactive Cover).

C. PROFESSIONAL CREDITIONALS

1. Qualification details

Degree obtained	Year achieved	Name of University	Year from	Year to

Additional training and affiliation

2. Please indicate any additional training received, including fellowships.

Institution	Year from	Year to	Name of programme / course	Certification received (e.g. ATLS)

3. If you have advanced life support training and certification, what date is this renewable? _____

Professional association or society

1. Are you a member of any professional association or society? Yes ☐ / No ☐

   If yes, please complete the following.

Professional Association or society	Year from	Year to	Position e.g. member, past or incoming president, EXCO

D. PROFESSIONAL ACTIVITIES

1. Please confirm the percentage breakdown of the professional activities offered by you and for which you require cover:

	%
	%
	%
	%
Total	100%

2. Should you perform any surgical procedures in an office-based setting (procedures performed under general, conscious sedation, spinal or caudal anaesthesia) then please confirm what these procedures are below:

3. Do you provide Medico-Legal services? Yes ☐ / No ☐

   If Yes, please confirm the percentage of time spent providing these services. _____%

E. PRACTICE MANAGEMENT

1. Is it mandatory that all your patients sign consent forms for
   a. Consultations? Yes ☐ / No ☐
   b. Surgical procedures and / in theatre treatment Yes ☐ / No ☐
2. What is the current system you use for patient notes? Hard copy ☐ / Electronic ☐

   If electronic, please specify which system you use: _____
3. What are the procedures in place to secure these records?

   _____
4. What are the procedures in place in your practice for dealing with patient complaints?

   _____
5. How long do you retain patient's medical records? _____

F. FEE INCOME

1. Please indicate the Gross taxable turnover for the relevant periods shown below:

Annual total	Annual Gross Income for The previous financial year	Annual Gross income estimated the next financial year
Annual practice	_____	_____
Government practice	_____	_____

2. Please indicate the % time spent in your Professional Capacity in:

   State Hospital _____% **Private Hospital** _____%
3. How many hours a week do you spend in :

   State Hospital _____Hours **Private Hospital** _____Hours
4. State the number of:
   a. **Annual Consultations** Previous year _____ Current year _____
   b. **Annual procedures / surgical treatments performed** :

      Previous year _____ Current year _____

G. TELEHEALTH

Telehealth Consultations

1. Have you in the past or do you in the future intend to use any of the following platforms of offer medical advice to any of your patients?

☐ WhatsApp ☐ Email ☐ Telephone ☐ Skype ☐ Medici ☐ Other (please specify) _____

2. Where telehealth is being practiced, would you ever offer medical advices to a patient with whom you have never previously had a physical consult? Yes ☐ / No ☐

3. Do you insist that there has to be a physical consultation between the patient and yourself within at least a 12 month period prior to telemedicine / virtual consultation: Yes ☐ / No ☐

4. How do you issue prescriptions following a telemedicine / virtual consultation?

☐ WhatsApp ☐ Email ☐ Telephone ☐ Skype ☐ Medici ☐ Other (please specify) _____

5. What is the current system you use to capture patient's notes from telemedicine / virtual consultation?

☐ Manual capture ☐ Electronic Capture Other _____

6. Do you always bill the patient/s for the telehealth/ virtual consultations Yes ☐ / No ☐

H. ADDENDUM

General Partitioners

Please indicate the breakdown of your procedures in an average year as follows:

Area	% Split	Area	% Split
Accident & Emergency		Obstetrics	
Anaesthetics		Minor Procedures performed in rooms	
Cosmetic & Aesthetic		Procedural (incl basic scans; excl obstetrics)	
Detailed Pregnancy scans		Surgical Assistance in Theatre	

I. PROFESSIONAL CLAIMS HISTORY

Where additional details are required, please supply these in the space provided at the end of this section.

1.	Has your professional status or professional role / job changed in the past 12 months?	Yes ☐	No ☐
2.	Have you had any break in clinical practice over the past 5 years?	Yes ☐	No ☐
3.	Has it ever been suggested by your employer, peers and / or third party that you be mentored and / or placed under supervision?	Yes ☐	No ☐
4.	Have you ever been the subject of an inquiry by your employer, a non-regulatory professional body and / or third party like a hospital or medical scheme? (e.g. following a patient complaint)	Yes ☐	No ☐
5.	Have you ever had conditions imposed on your practice, been suspended or removed from the medical register due to a complaint, inquiry or investigation?	Yes ☐	No ☐
6.	Has any indemnity provider, in respect if the risks to which this application relates to, ever:		
-	Declined an application, refuse renewal or withdrawn a cover ?	Yes ☐	No ☐
-	Required an increased premium or imposed special conditions, including participation in risk management / educational programme?	Yes ☐	No ☐
-	Declined an indemnity insurance claim by the insured or reduced its liability to pay an insurance claim in full (other than application of an excess)?	Yes ☐	No ☐
7.	Have you ever received a regulatory complaint (e.g. HPCSA, OHSC) letter of demand or summons arising out of your professional practice?	Yes ☐	No ☐
	If Yes, please specify details in the template provided in **Annexure A.**		
8.	Except for the cases that you have listed above, in the past three years, have you had a patient threaten legal action against you in your professional capacity, received a request for records, received a patient complaint / inquiry via a lawyer, been involved in an inquest or received a subpoena in a medical case?	Yes ☐	No ☐
	If Yes, please specify details in the template provided in **Annexure B.**		
9.	If there are any other issues and / or concerns that you may reasonably consider to be important and that we should be aware of in recording your professional conduct, please share these below. These should include interactions with foreign regulatory authorities and Healthcare Systems.		

10. Additional details:

J. ATTESTATION

Please attest to the following statement. If you **DISAGREE** with any of the statements, please provide additional and complete information in the space provided at the end of this section.

1. I have never had my license to practice medicine and / or license to dispense medicines revoked or limited.	Agree ☐	Disagree ☐
2. I have never been charged or convicted of any criminal offence.	Agree ☐	Disagree ☐
3. I have never had any hospital privileges restricted, suspended, whether voluntarily or involuntarily, and I am not currently under investigation by any hospital.	Agree ☐	Disagree ☐
4. I do not perform any procedures that are outside the customary scope of practice for which I am applying for coverage.	Agree ☐	Disagree ☐
5. I have never been part of a forensic audit by a medical scheme and I have never had a payment by a medical scheme reversed for reasons of alleged over-billing / over-servicing.	Agree ☐	Disagree ☐
6. I have never been declared an "impaired physician" by the HPCSA.	Agree ☐	Disagree ☐

Additional Attestation Information:

_____

_____

If retro-active cover is required, please also attest to the following and provide additional and complete information at the end of this section.

I have notified my current / previous insurer(s) of all the following for the time period for which backdated cover is being requested:

1. Requests for records (for reasons other than processing of RAF or COID applications) from a patient, family member / custodian of a patient, or an attorney.	Agree ☐	Disagree ☐
2. Letter from an attorney regarding diagnosis treatments and / or advice that I provided to a patient.	Agree ☐	Disagree ☐
3. Threat of a legal, including HPCSA, claim against me in my professional capacity, even if such action is without merit.	Agree ☐	Disagree ☐
4. Any unexplained and / or unusual clinical outcome.	Agree ☐	Disagree ☐
5. An awareness of a failing or short-coming of my work, or real doubt about my clinical performance or party for whom I am responsible in the course of my professional activities, which could give rise to a third-party loss.	Agree ☐	Disagree ☐
6. HPCSA complaints, even if you deem these to be without merit.	Agree ☐	Disagree ☐

Additional Attestation Information:

_____

_____

K. DECLARATION

I, **the undersigned, am duly authorized and declare that:**

- I certify that the following contained in this application is true, correct and complete to the best of my knowledge, and that reasonable inquiry has been made to obtain the answers herein;
- I have disclosed all material facts to the underwriting of the risks to be insured and will continue to do so whilst my policy is in force;
- I understand that the information contained in this application for insurance, which insurers have relied upon, shall form part of the basis of the contract of insurance;
- I do and will always, and for the duration of my insurance, maintain my registration in good standing with all relevant regulatory and / or professional bodies;
- I understand that signing this application form does not bind myself to complete this insurance, nor does it bind the insurer to accept my application;
- I undertake to inform insurers of any material change to these facts, whether occurring before or after completion of the insurance contract and that insurers may withdraw or modify any outstanding quotations and / or authorizations or agreement to bind the insurance;
- I understand that any failure on my part to notify insurers of any material changes be grounds for cancellation of the insurance contract.

I hereby authorize and consent to Alphabelle:

- Obtaining any documentation, information and data, including my claims history, relating to my insurance cover held by my previous and current indemnity provider(s), which includes my membership with the Medical Protection Society;
- Approaching any person, including the Health Professions Council of South Africa, and any other professional body, hospital (i.e. any Private or State facility), medical scheme or insurer for any information concerning my practice, including practice statistics and details regarding my diagnosis and treatment of patients and any claims against me or any inquest, criminal proceedings or litigation in which I am or have been involved as party or witness;
- Obtaining any documentation, information and data, relating to my practice from various hospitals, including State facilities, as and when may be required from time to time;
- Processing all facts disclosed and obtained, for the purposes of assessing my risk profile and / or underwriting the risks and relating to performance of any policy rights and obligations and promoting good health care practices;
- Using my anonymised data for research and education.

Your signature	Date
Your name & surname	

ANNEXURES

Annexure A: Previous case history – regulatory complaint (e.g. HPCSA, OHSC), letter of demand of summons.

Insurer	Case number	Complaint type	Year of incident	Monetary amount claimed	Case description	If case is closed, what was the outcome (e.g. sanction type imposed, monetary settlement paid)?

Annexure B:

Previous case history – notification, advice/assistance, request for records, written complaint, mediation, inquiry, inquest, subpoena (note: where a request for records is known to be against a third party, this should be noted).

Insurer	Case number	Complaint type	Year of incident	Case description