MEDICAL MALPRACTICE PROPOSAL FORM

For Allied Healthcare Practitioners

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

PLEASE READ BEFORE COMPLETING THIS DOCUMENT

This is a proposal for a claims made policy.
The policy will only respond to claims and/or circumstances, which are first made against the Insured and notified to the Insurer during the policy period.
The policy will NOT provide cover for:

- Events that occurred prior to the retroactive date of the policy.
- Claims made after the expiry of the policy period even though the Wrongful Act giving rise to the claim may have occurred during
  the policy period.
- Claims notified or arising out of facts or circumstances notified under any previous policy or noted on the current proposal form or any previous proposal form.
- Claims made, threatened or intimated prior to the commencement of the policy period.
- Facts or circumstances in your knowledge prior to the policy period, which you knew had the potential to give rise to a claim under the policy.

Documents required:

- Completed, signed and dated proposal form
- Copy of HPCSA / AHPCSA Registration ☐
- CV and copy of all qualifications (New Applications or change in scope of practice) ☐
- Copy of all consent forms used in practice. ☐
- Copy / Example of records used in practice (New Applications or change in scope of practice) ☐
- Proof of previous insurance (if moving from another insurer) (New Applications or change in scope of practice) ☐
- Claims Information (if applicable) ☐
- Addendum 1 to be completed in respect of Psychologists and similar professions ☐

Every question on the proposal form is relevant to your risk, so please do not leave any blank, if it doesn't apply please state "N/A". If there is any part of this document you do not understand, please contact us before you sign and submit it. You are bound to the information you have provided with this submission

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. APPLICANT'S DETAILS

Your Organisation

1. Surname _____ Title(s) _____
2. First name(s) _____
3. Gender _____ ID Number _____
4. Trading name (if different from the above) _____
5. Cell No. _____ Email Address _____
6. VAT No. _____ HPCSA Reg no. _____
7. Practice Address _____

   Suburb _____

   City _____ Province _____

If cover is required for more than one location, please attach a list of all addresses

B. PROFESSIONAL DETAILS

Registration and qualifications

Please provide full details of all qualifications and courses that you have undertaken, on the above branches of medicine and include dates of qualification, and how long you have been practicing in these fields

1. How long have you been in practice | Years | Months | Practice Number(s) _____
2. Qualification details

Degree obtained	Year achieved	Name of University	Year from	Year to

Additional training and affiliation

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

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

2. 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 president or incoming president, EXCO

If you are an Employee, please state the name of the company (or other entity) for whom you work.

_____

Please give a full description of your business activities for which cover is required.-_____

_____

C. PREVIOUS INSURANCE COVER

Professional Indemnity (PI) cover

a. 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	Limit of insurance

b. **Please provide a copy of your current PI schedule (mandatory if requesting Retroactive Cover).**

D. DECLARATION

Confidential Professional Information / Claims

Have any claims / incidents / circumstances for malpractice been made against you / practice during the past five years?	Yes ☐	No ☐
Are any of the Principals or Employees of the practice, after enquiry, aware of any circum- stances that may give rise to a claim for professional negligence, errors or omissions or public liability?	Yes ☐	No ☐
Have you had any civil or criminal actions against you, where there was a finding of liability or guilt with respect to your clinical practice?	Yes ☐	No ☐
Has a criminal claim of any nature ever been made against you / your practice?	Yes ☐	No ☐
Has any application for insurance of this nature (made on behalf of the Practice or their pre-decessors in business or by any of the present Partners) ever been declined, cancelled or has renewal been refused or have special terms been imposed ?	Yes ☐	No ☐
Have you ever been investigated, or are currently under investigation by the HPCSA / relevant professional regulatory body overseas / medical scheme?	Yes ☐	No ☐
Do you have any physical or mental condition or substance abuse problems that could affect your ability to safely and competently undertake the provision of care?	Yes ☐	No ☐
Do you employ Locums to assist you at your practice *If YES, kindly ensure that all Locums have their own Professional Indemnity / Medical Malpractice Policy in place, as their activities will not be covered in terms of your Policy*	Yes ☐	No ☐
Does any person involved in the treatment and care of any patient/client suffer from any disability, transmittable diseases i.e. Hepatitis, HIV etc. or any other impediments which may affect the performance of his/her professional duties or place any patients/clients at risk?	Yes ☐	No ☐
Is there any additional information that may have significance, when we assess your individual risk, for example full time Hospital employment, academic involvement, registrar, etc	Yes ☐	No ☐

E. SCOPE OF CLINICAL PRACTICE

1. Do you undertake any services in a state-owned facility / government hospital or clinic? Yes ☐ / No ☐
2. Are you an employee of an institution? Please state name of entity for which you work. Yes ☐ / No ☐
3. Do you undertake any locum work? If yes, please detail locum work. Yes ☐ / No ☐
4. If a practice, please provide list of all staff in the practice.

Name	Position	Qualification	Part Time / Full Time

5. **In what AREA or branches of HEALTHCARE are you qualified and, if applicable, licensed to practice**

Acupuncture		Midwife / Doula / Lactation	
Aromatherapist		Occupational Therapist	
Audiologist/Speech Therapist		Optometrist	
Ayurveda		Oral Hygienist / Dental Therapist	
Biokinenticist		Orthotist / Prosthetist	
Care Giver		Osteopathy	
Chinese Medicine		Paramedic /Ambulance Attendant	
Chiropractice		Perfusionist	
Cytologist		Phytotherapist	
Dietician		Podiatrist	
Homeopathy		Psychologist	
Medical Physicist		Radiographer	
Medical Technologist		Reflexologist	
Natureopathy		Sexologist	
Nurse		Sonographer	
Sports Scientist		Other:	

6. Revenue / Fees (Gross) (Inclusive of VAT)

Financial Year End	Last Financial Year	Previous Financial Year	Estimated forth
Gross revenue from private practice			
Gross revenue from state institutions			
Gross Fees excluding Vat			
Gross revenue from other sources			
Total			

7. **Patients**

a. In the last 12 months, how many patients have you consulted with (actual): _____

b. Expected number of patients in the next 12 months _____

c. Total number of treatments / sessions / consultations in the last 12 months (actual) _____

d. Expected number of treatments / sessions / consultations in the next 12 months _____

8. **Additional Information**

8.1. What equipment (if any) is being used to perform treatments: _____

8.2. What is the age group breakdown of the patients you provide treatment to: _____

8.3. Do you prescribe and/or supply any products (including medicines, creams etc.) Yes ☐ / No ☐

If yes, please provide :

Product	Use (Internal / External)	Supplier / Producer	Approximate fees

F. RISK MANAGEMENT

1. Is it mandatory that all your patients sign a consent form for consultations? Yes ☐ / No ☐
2. Are accurate and descriptive records of all medical services and procedures kept? Yes ☐ / No ☐
3. What system is in place for capture patient notes?

   _____

4. How are your patient records secured? _____
5. How long do you retain patient's medical records: _____
6. Please detail procedures in place in dealing with patient complains.

   _____

7. Do you have an internal risk management protocol? Please provide copy of protocol Yes ☐ / No ☐
8. Disposal of medical waste

   Are there facilities for safe collection, storage and disposal of (in accordance with current guidelines / legislation):-

   i) Sharp Yes ☐ / No ☐
   ii) Dressings, clinical and surgical waste, etc Yes ☐ / No ☐

   Do you ensure that the following are safely disposed of (in accordance with current guidelines/legislation)

   i) Blood and blood products Yes ☐ / No ☐
   ii) All other waste Yes ☐ / No ☐

Limit of Indemnity Required: R_____ Deductible Required : R_____

- **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 understand that any incorrect statement in this application and the attached supporting documents including (but not restricted to) qualifications, experience, scope of practice, ability, physical or mental health or personal integrity, may result in refusal of a cover.
- 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 Alphabelle (Pty) Ltd of such changes as soon as reasonably possible.
- You are bound to the information you have provided with this submission. Completion of the form, however, does not bind you or Insurers to complete the insurance transaction. The contract of insurance can only be finalized once we are in receipt of the fully completed and signed proposal form together with acceptance of quotation and payment. Any new additional entity being formed, or any material changes made to the business which could impact the cover provided must be advised to insurers as cover will not automatically be granted.

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 overseas regulated societies (e.g. Medical Protection Society), if applicable;
- 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 Alphabelle may require 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	