MEDICAL MALPRACTICE PROPOSAL FORM

For Healthcare Institutions

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.

☐

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. YOUR ORGANISATION

1. Name of Insured _____

2. Have you ever carried out medical services under a different name? Yes ☐ / No ☐

3. If YES, provide details _____

4. Contact person _____ Email Add _____

5. VAT No. _____ Reg No. _____

6. Practice Address _____

   Suburb _____

   City _____ Province _____

7. Location of branch offices _____

8. Do you have any subsidiary companies that you require cover for? Yes ☐ / No ☐

9. Please give full description of your business activities for which cover is required.

B. EXPERIENCE AND QUALIFICATIONS

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

Name	Shareholding (%)	Experience / Qualifications

11. **Revenue**

a. When is your financial year end	
b. What are your estimated fees for the coming 12 months	
c. Please provide gross revenue (VAT Inclusive) received	

Gross Revenue	Last Financial Year	Previous Financial Year	Estimated forth
Hospital / Clinic			
Rentals / Leases			
Medical procedures / Treatments			
Pharmacies			
Any other source			
Total			

12. Do your activities involve a joint venture with any other company, partnership, individual or other professional grouping? Yes ☐ / No ☐

If Yes, please provide details.

13. Will the activities involve new or incoming partners that are involved in your activities during the next 12 months. Yes ☐ / No ☐
If Yes, please provide details.

14. Are public funds, private funds or endowments used to maintain the Insured, either in whole or in part? Yes ☐ / No ☐
If Yes, please provide details.

15. Are any beds or services available to the community on a charitable basis? Yes ☐ / No ☐
If Yes, please state percentage.

16. Please state number of beds maintained.
    a. Full pay beds or part-pay beds (other than bassinets for maternity cases). _____
    b. Charity beds (other than bassinets). _____
    c. Maternity beds (i.e. bassinets). _____

17. Number of babies delivered on an annual basis.
    a. Does the Insured have a neo-natal ward. _____
    b. Number of bassinets / cribs. _____
    c. Ratio of nurses to babies. _____

18. Number of operating theatres _____

19. Average annual bed occupancy. (Calculated by noting the occupancy at any specific day of each month and dividing the aggregate total of 12 months by 12.) _____

20. In respect of medical services at the address specified above, are you in possession of the registered licenses and or registrations from the applicable regulatory body, or as required by law. Yes ☐ / No ☐

If No, please provide details

21. **Please state number of employees in each of the following classifications.**

Staff Compliment	No. of Employees	No. Self-Employed	No. of Years Practising
Anaesthesiology			
Cardiac / Thoracis / Vascular Surgery			
Dental Surgery / Maxilla-Facial			
Dentist / Orthodontist			
Dermatology			
ENT			
General Practitioner			
General Surgery			
Gynaecologists			
Internal Medicine			
Lab / Pathology Technicians			
Neonatology			
Neurology			
Nurses:			
Sports Scientist			
a. Enrolled Nurses			
b. Matrons			
c. Midwives			
d. Nurse Anaesthetist			
e. Registered Nurses			
f. Student Nurse			
g. Auxiliaries Nurses – Qualified			
Care Workers			
Obstetrics			
Orthopaedics			
Paediatrics			
Paramedics			
Pharmacists			
Plastic Surgery			
Radiology			
Residential Medical Officers			
Urology			
Directors / Partners / Principals			
Administration			
Other			
Total			

22. Please state the approximate division of your patients between:

Major Surgery		ENT	
Minor Surgery		Dental / Maxillofacial	
Cosmetic Surgery		Accident & Emergency	
Orthopaedics		Drug / Alcoholic	
Obstetric		Communicable Infectious Diseases	
Ophthalmology		Frail Care / Aged	
Prosthetic Fitment		Insanity / Psychiatric	

23. Which associations, professional bodies or self-regulatory organisations is the Insured a member of or registered with

24. Are you a member of a group of hospitals? Yes ☐ / No ☐
If Yes, please provide details.

25. Are you affiliated to any other medical interest. Yes ☐ / No ☐
If Yes, please provide details.

26. Please state number of X-Ray machines / M.R.I./ C.A.T. or similar scanners owned or operated, and whether they are used for

a. Diagnosis _____

b. Treatment _____

27. Do you administer Radium, or any other forms of radio-active treatment? Yes ☐ / No ☐
If Yes, please provide details.

28. Is any telemedicine undertaken by the Insured. Yes ☐ / No ☐
If Yes, please provide details.

29. Do you operate any road or air ambulance services. Yes ☐ / No ☐
If Yes, please provide details.

30. Do you use nurse anaesthetists? Yes ☐ / No ☐
31. Do you ensure that they carry individual medical malpractice cover? Yes ☐ / No ☐
32. Do you have a fully qualified anaesthesiologist available on site at all times? Yes ☐ / No ☐
33. Do you have a Blood Bank? Yes ☐ / No ☐
34. Do you provide fertility treatments/drugs/contraceptives? Yes ☐ / No ☐
35.
    a. Do you undertake clinical trials, or provide facilities at which clinical trials can be undertaken. Yes ☐ / No ☐
    If Yes, please state all active trials during the last 12 months.

    b. Are the trials being conducted at your premises approved by the Medical Council of South Africa. Yes ☐ / No ☐
    c. Have the trials been registered with The South African Clinical Trial Register (SANCTR). Yes ☐ / No ☐

36. Do you undertake surgical procedures, including transplants. Yes ☐ / No ☐
    If Yes, please provide details.

37. Are accurate and descriptive records of all medical services and procedures kept. Yes ☐ / No ☐

38. How are they stored, where and for how long? _____

39. Do you undertake staff training? Yes ☐ / No ☐
    If Yes, please provide details.

40. Do you undertake to ensure that trainees carry out their duties under proper supervision.
41. Do you maintain Clinics (e.g. Mammograms, antenatal Clinics, Renal Clinics etc.)?
    a. Type
    b. Free patients/full pay/part pay.
    c. Number of:
        i. Clinics
        ii. Doctors
        iii. Nurses
    d. Estimated total number of patients per year.
    e. Estimated number of foreign patients treated per year.

42. Do your staff receive any formal medical malpractice risk management training? Yes ☐ / No ☐
43. Are all buildings owned or used by you in good state and regularly maintained / repaired? Yes ☐ / No ☐

44. Are the following regularly checked, serviced and repaired by fully qualified contractors.

a. Air Conditioning Units Yes ☐ / No ☐
b. Electricity Generators (including any emergency backup generators) Yes ☐ / No ☐
c. Escalators Yes ☐ / No ☐
d. Heating Systems and Boilers Yes ☐ / No ☐
e. Hoists Yes ☐ / No ☐
f. Incinerators Yes ☐ / No ☐
g. Lifts Yes ☐ / No ☐
h. Water Tanks Yes ☐ / No ☐
i. Sprinkler System Yes ☐ / No ☐

45. Please provide details of any subcontracted functions or facilities.

46. Do you ensure subcontractors carry their own insurance? Yes ☐ / No ☐
47. Are there facilities for safe collection, storage and disposed of (in accordance with current guidelines / legislation)
    a. Sharps Yes ☐ / No ☐
    b. Dressings, clinical and surgical waste, etc. Yes ☐ / No ☐

48. Do you ensure that the following are safely disposed of (in accordance with current guidelines/legislation).
    a. Blood and blood products Yes ☐ / No ☐
    b. All other medical waste Yes ☐ / No ☐

GENERAL INFORMATION

49. 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.

50. 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.

51. Has any application for insurance of this nature (made on behalf of the Practice your predecessors 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 ☐

    If Yes, please provide details.

C. QUOTE REQUEST

52. Limit of Indemnity R_____ R_____ R_____

D. PREVIOUS INSURANCE COVER

53. 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

E. 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	