MEDICAL MALPRACTICE PROPOSAL FORM

For Private Practice Specialists

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 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.

Should 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. Surname _____ Title(s) **DR** _____
2. First name(s) _____
3. Gender _____ ID Number _____
4. Cell No. _____ Email Address _____
5. VAT No. _____ HPCSA Reg no. _____
6. Practice Address _____

   Suburb _____

   City _____ Province _____

B. QUOTATION DETAILS

1. What type of quotation would you like?

Claims-made	Yes ☐ / No ☐
Occurrence-based	Yes ☐ / No ☐
Both	Yes ☐ / No ☐

2. If you are currently on Claims-made cover, do you require retroactive cover? Yes ☐ / No ☐

   From? _____

   Description:
   Retroactive cover – this ensures that you have cover for claims which you are currently unaware of, that might arise from work prior to taking out the new policy.

C. 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).

D. PROFESSIONAL DETAILS

Registration and qualifications

1. Practice Number(s) a. _____ b. _____ c. _____

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

- 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

E. 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 a 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 of the risks to which this application relates to, ever:		
	- Declined an application, refused renewal or withdrawn cover?	Yes ☐	No ☐
	- Imposed an extraordinary increase in premium and / or special conditions, including participation in risk management / educational program?	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 five years, have you had a patient threaten legal action against you in your professional capacity, received a request for records, received a patient complaints / 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:

F. PRACTICE DETAILS

Please provide us with your practice details for the period of insurance for which you are applying. For example, if you are currently a full-time employee in State, but are applying for insurance to cover you in private practice, answer questions in relation to your anticipated **private** practice.

Type of practice

Do you perform any work for the state? Yes ☐ / No ☐

If yes, please complete the "State employment" section first. If no, complete the "Private practice" section only.

State Employment

1. Please specify type of State employment:
   - Permanent staff ☐ Sessional doctor ☐
2. If you are a full-time State employee, please specify level of employment: -
   - Head of Department ☐ Consultant ☐
   - Other ☐ please specify: _____
3. Please indicate at which **State** hospital / clinic you work.

Name of Hospital / Clinic	% of government work performed

4. What is your % split in terms of hours spent between State and Private work?
   - % State _____ % Private _____
5. Are you planning to enter private practice full-time? Yes ☐ / No ☐

   If yes, please provide the approximate date: _____
6. Please complete your work schedule for private and public sector work as per the example. Only to be completed by full-time State employees.

Time	Example for Monday	Mon	Tues	Wed	Thu	Fri	Sat	Sun
AM	State hospital name							
	Activities (e.g. consulting)							
PM	Private hospital name							
	Activity (e.g. theatre)							
After hours	State hospital name							
	Activity (e.g. on call)							

7. If you are recently qualified and are entering private practice for the first time, do you have assistance from a senior colleague for complex cases? Yes ☐ / No ☐ OR N / A ☐

If yes, please provide details: _____

Private practice

1. Please specify type of private practice. Tick all the boxes that are applicable.
   - Solus private practice ☐ - Private practice partnership ☐ - Private group practice ☐
   - Associate ☐ - Locum (clinical work) ☐
   - Salaried ☐ (if selected, please specify) Employer: _____
   - Position held: _____
   - Other _____

2. Please indicate name(s) of hospital(s) where you treat patients in a private capacity.

Name of hospital	Hospital group	% of your private patients admitted per annum

3. Year of first seeing private patients as a specialist: _____

Practice management

1. Will other staff in your practice (i.e., doctors, allied healthcare professionals and / or non-clinical staff) provide clinical services for which you would be vicariously responsible (e.g., nurse providing primary care services, beautician providing laser therapy, doctor employed in your practice)? Yes ☐ / No ☐

If yes, please specify details below.

Name	Practitioner type e.g., GP, specialist, nurse, physiotherapist	Are they registered with the relevant Health Professions Council? (Y/N)	Personal professional indemnity cover (Y/N)

2. Do you employ locums? Yes ☐ / No ☐

   If yes, please specify details below:

   - Do you ensure that they are registered with the HPCSA? Yes ☐ / No ☐
   - Do you ensure that they carry indemnity cover? Yes ☐ / No ☐

3. Do you have colleagues that cover your practice when you are unavailable, including in the event of an emergency? Yes ☐ / No ☐

   If no, how do you ensure that your patients can access emergency care when you are not available?

   _____

   If yes, please provide their names and describe the business relationship (e.g. call roster, partnership):

Name & Surname		

   If yes, do they carry indemnity cover? Yes ☐ / No ☐ / Unsure: ☐

4. Do you see your in-hospital private patients on a daily basis? Yes ☐ / No ☐

   If no, who provides this care? _____

5. Do you provide clinical services in private facilities as part of a State contract or alternative reimbursement model a like capitation agreement? Yes ☐ / No ☐

   If yes, please provide details: _____

Patient records

1. Do all your patients sign consent for consultations? Yes ☐ / No ☐
2. Do all your patients sign consent for surgical procedures, and /or in-theatre treatments? Yes ☐ / No ☐
3. Who in your practice takes informed consent from patients?

   _____

4. What is the current system you use for patient notes? Hard copy ☐ / Electronic ☐

   If electronic, please specify which system you use: _____

5. What are the procedures in place to secure these records?

_____

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

_____

7. Do you comply with HPCSA's guidelines on keeping patient records? Yes ☐ / No ☐ / Unsure: ☐

Practice income

i) **Gross annual income** in relation to **government** clinical professional services rendered: R_____

ii) **Gross annual income** in relation to **private** clinical professional services rendered: R_____

iii) **Gross annual fees** in relation to medico-legal services: R_____

G. SCOPE OF WORK FOR PRIVATE PRACTICE

To be completed for **private practice** work only. Do not include statistics in terms of any work performed in the State sector.

International patients

1. Do you regularly treat international patients who have travelled to receive treatment from you? Yes ☐ / No ☐

   If yes, how many on average in the past 12 months? _____

2. List all the mechanisms used, if any to attract international patients:

   _____

3. Will you regularly repatriate patients? Yes ☐ / No ☐

Scope of practice

Where possible, please specify current and anticipated future figures

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

	%
	%
	%
	%
	100%

2. Will you conduct / participate in clinical trials? Yes ☐ / No ☐

3. On average, how many patients do you consult per month?

Past year	Coming year

4. Do you perform aesthetic / cosmetic procedures e.g., Botox, non-permanent fillers, chemical facial peels, collagen injections, hair transplants without flap surgery, laser therapy, thread lifting, liposuction or sclerotherapy?

Yes ☐ / No ☐

If yes, please specify details: _____

5. Do you perform in-theatre surgical procedures? Yes ☐ / No ☐

If yes:

- How many procedures do you perform on average **per annum** as primary surgeon?

Past year	Coming year

- On average, in how many procedures **per annum** do you act as an assistant surgeon?

Past year	Coming year

- Do you treat children (12 years of age or younger)? Yes ☐ / No ☐

If yes, what percentage of your patient base do they represent?

Past year%	Coming year%

- If you only provide surgical assistance (as opposed to acting as the primary surgeon), please complete the following: - How many surgeons do you assist regularly?

Past year	Coming year

- Is your assistance limited to holding instruments in theatre to support the primary surgeon? Yes ☐ / No ☐

If no, please provide **as much details** as possible (e.g., position the patient and start surgery to prepare operative field, perform surgical closure, provide post-operative care, teach/supervise a particular skill):

_____

- Please list your commonly performed procedures **per annum** as **primary** surgeon.

Procedures	Number performed in past year	Number expected to be performed in coming year

6. Do you provide chronic pain management?

If Yes, please provide us with details regarding the chronic pain management provided.

_____

7. Do you perform Radiofrequency Ablation?
If Yes, please provide a copy of your certificate of training and / or list of courses attended.

_____

8. Do you perform any **procedures under conscious sedation** in an **office-based setting** i.e., not in an emergency unit or hospital theatre? Yes ☐ / No ☐

If yes, please specify:

- Type of procedures performed under conscious sedation:

  _____

- Who administers conscious sedation? You as the practitioner ☐ Other practitioner ☐

  If other, please specify (e.g., anaesthetist, GP):

  _____

9. Do you perform **conscious sedation** other than in an emergency unit or hospital theatre? Yes ☐ / No ☐
If yes, please complete the following:

- Do you perform conscious sedation in your rooms or another practitioner's rooms? _____
- If you administer the conscious sedation drugs and also perform the associated procedure, what type of practitioner assists you, if any (e.g., nurse)?

  _____

- Unless specified in point 5 above, for which procedures do you perform conscious sedation?

  _____

- What drug regiment(s) do you use?

  _____

- Do you have emergency protocols in place? Yes ☐ / No ☐
- Do you keep a logbook of all cases? Yes ☐ / No ☐
- Are the facilities in which you carry out conscious sedation accredited by SOSPOSA or COHSASA? Yes ☐ / No ☐
- Are these facilities equipped with the necessary equipment and drugs required in an emergency? Yes ☐ / No ☐
- Is resuscitation equipment checked and maintained regularly? Yes ☐ / No ☐
- Is the facility where sedation takes place within a hospital building with an ICU? Yes ☐ / No ☐
  If no, in what proximity is the closest ICU?

  _____

- Do you perform conscious sedation on children under age 1 year or pregnant women? Yes ☐ / No ☐
- Do you have informed consent forms specific to conscious sedation? Yes ☐ / No ☐
- Do you keep sedation monitoring charts? Yes ☐ / No ☐
- Do you provide patients with post-discharge patient information leaflets? Yes ☐ / No ☐
- Average number of patients sedated per annum

Past year	Coming year

If available, please submit copies of informed consent forms and other documentation such as sedation monitoring chart and post-discharge patient information leaflet that you may be using where you perform conscious sedation.

10. Other than clinical services described in your answers, are there any other professional activities like, for example, voluntary work or paid advisory services to companies, for which you may require assistance should an adverse event arise from such activity? Yes ☐ / No ☐

    If yes, please provide details:

    _____

11. Do you practice Telehealth other than as a consulting practitioner to the primary caregiver? Telehealth includes the remote diagnosis and treatment of new patients and new conditions of existing patients by means of telecommunications technology. Yes ☐ / No ☐

    If yes, please provide details:

    _____

12. Will you do procedures that may be deemed to be experimental (e.g., not generally performed by your colleagues for reasons of limited evidence)? Yes ☐ / No ☐

    If yes, please provide details:

    _____

13. Do you have a field of special interest within your area of practice? Yes ☐ / No ☐

    If yes, please provide details:

    _____

Specialty-specific services

Please only complete the section relevant to your specialty.

Cardiologist

Do you perform any valve replacements or minimally invasive neurovascular interventions like endovascular treatment of aneurysms and strokes? Yes ☐ / No ☐

If yes, please provide details: _____

H. 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 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 ☐

If retro-active cover is required, please also attest to the following and provide additional and complete information at the end of the 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 ☐	N/A ☐
2. Letter from an attorney regarding diagnosis, treatments and / or advice that I provided to a patient.	Agree ☐	Disagree ☐	N/A ☐
3. Threat of a legal, including HPCSA, claim against me in my professional capacity, even if such action is without merit.	Agree ☐	Disagree ☐	N/A ☐
4. Any unexplained and / or unusual adverse clinical outcome.	Agree ☐	Disagree ☐	N/A ☐
5. An awareness of a failing or short-coming of my work, or real doubt about my clinical performance or a party for whom I am responsible in the course of my professional activities, which could give rise to a third-party loss.	Agree ☐	Disagree ☐	N/A ☐
6. HPCSA complaints, even if you deem these to be without merit.	Agree ☐	Disagree ☐	N/A ☐

Additional Attestation Information:

_____

_____

_____

I. 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 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	

ANNEXURES

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