Camarguе

Specialised Liability Management

MEDICAL MALPRACTICE
HOSPITALS AND CLINICS

PROPOSAL FORM

IMPORTANT NOTICE

- Answer all questions leaving no blank spaces.
- If you have insufficient space to complete any of your answers, continue on your headed paper.
- It is the intention of Underwriters that any Contract of Insurance with the Proposer shall be based upon the answers and information provided in this Proposal Form and any other additional information provided by the Proposer. If a quotation is offered it will be the intention of Underwriters to offer coverage only in respect of those entities named in answer to Question 1.
- Completion of this form does not bind the Proposer or Insurer to complete the insurance transaction.

1 | GENERAL INFORMATION

Details of entities to be insured (the "Proposer")

Proposer's Name:

ID number (if Sole Trader):

Head Office (Physical Address):

Postal Code:

Postal Address:

Postal Code:

Company Reg No: VAT No:

Professional Association(s):

Contact Person: Contact number:

Email: Website:

Date Company Established / Services Commenced: / /
As currently constituted *(If commenced within the past 24 months – Please attach CV of key personnel/Directors/Principals)*

Date Company Established / Services Commenced: / /
As initially established

Company Legal Constitution: Partnership / Private Company / Public Company / Close Corporation / Non-profit Organisation / Government / Sole Proprietor

AUTHORISED FINANCIAL SERVICES PROVIDER, LICENCE NUMBER: 6344. APPROVED LLOYD'S COVERHOLDER PIN: 107824DRW
Camargue Underwriting Managers (Pty) Ltd. Co. Reg. No. 2000/028098/07.
33 Glenhove Road, Melrose Estate, 2196. Postnet Suite 250, Private Bag X4, Bedfordview 2008
Telephone: 011 778 9140, Facsimile: 011 778 9199, E-mail: camargue@camargueum.co.za, Website: **www.camargueum.co.za**

Underwritten by certain underwriters at Lloyds, Compass Insurance Company Limited and Bryte Insurance Company Limited

PLEASE NOTE that in order for a Subsidiary to be included in the cover, the Subsidiary company must be named in the Proposal Form with its principal business activity and the first named Insured's shareholding interest so indicated.

Name of Subsidiary	Location	Date Established	Principal Activity

2 | INSURANCE HISTORY

1 **Are you in the present or have you in the past been Insured, for the type of Insurance now being proposed?** Yes ☐ No ☐

If Yes, please state: Insurers:

Limit of Indemnity:	R
Excess:	R
Premium:	R
Date of expiry of coverage:	
Retroactive Date:	

2 **For the type of Insurance now being proposed, has any Insurer ever:**

i) Required an increased premium or imposed special terms? Yes ☐ No ☐

ii) Refused to accept or renew any insurance for the body corporate Yes ☐ No ☐

iii) Cancelled the insurance? Yes ☐ No ☐

If any answer is Yes to any of the above 3 questions, please provide full details

3 | REQUIRED COVER

1 **State the LIMIT OF INDEMNITY and EXCESS required:**

Limit	R	R	R
Excess	R	R	R

2 **Do you require cover in respect of liability incurred but not discovered prior to the effecting of this insurance at a single premium to be negotiated?** Yes ☐ No ☐

4 | PREVIOUS LOSSES/ EXISTING CIRCUMSTANCES

1 **Is any Principal, AFTER FULL ENQUIRY, aware of any circumstance which might:**

i) Give rise to a claim against the Proposer, any predecessor or any past or present Principal? Yes ☐ No ☐

ii) Cause any loss to the Proposer, any predecessor or any past or present Principal? Yes ☐ No ☐

iii) Otherwise affect the consideration of this proposal for insurance? Yes ☐ No ☐

If Yes, please provide details:

2 In respect of ANY of the risks to which this proposal relates, has any Claim been made (whether successful or not) against the Proposer or any past or present Principal?

Yes ☐ No ☐

If Yes, please identify details (including loss date, amount claimed and a brief description):

3 What steps have been taken to prevent a recurrence?

4 Have you ever been subject to any disciplinary proceedings by the HPCSA, criminal prosecutions or inquest proceedings? If so, please provide full details.

5 Are you aware, after due consideration, of any claims or complaints that may be made against you or your practice? If so, please provide full details.

6 Is there any other information which you consider material to the risks to be insured that should be disclosed?

5 | ACTIVITIES OF PROPOSER

Please state the disciplines in which the Proposer is engaged.

6 | STAFF COMPLIMENT

	No. of employees	No. Self-Employed	No. of years of practising
Anaesthesiology			
Auxiliaries non-qualified			
Auxiliaries nurses -qualified			
Cardiac/Thoracic/Vascular Surgery			
Cardiology			
Dental Surgery/ maxilla-facial			
Dentist/Orthodontist			
Dermatology			
ENT			
General Practitioner			

	No. of employees	No. Self-Employed	No. of years of practising
General surgery			
Gynaecologists			
Internal medicine			
Lab/Pathology technicians			
Neonatology			
Neurology			
Nurses:			
i) Enrolled nurses			
ii) Matron			
iii) Midwives			
iv) Nurse Anaesthetist			
v) Registered nurses			
vi) Student Nurses			
Care workers			
Obstetricians			
Orthopaedic			
Paediatrics			
Paramedics			
Pharmacists			
Plastic surgery			
Radiology			
Residential Medical Officers			
Urology			
Directors/Partners/Principals			
Administration			
Other(please provide details)			
Total			

7 | FINANCIAL INFORMATION

When was your immediate past Financial Year End: ....

Please state:	As at immediate Past Financial Year End	As at Previous Financial Year End
Gross Revenue of the Hospital/Clinic	R	R
Gross Revenue relating to Rentals/Leases	R	R
Gross Revenue from medical Procedures/Pharmacies or any other Medical Treatment	R	R
Gross Revenue from any other source (provide brief details).	R	R
Total Revenue	R	R

8 | GENERAL INFORMATION

1 **What level of healthcare is delivered (primary, secondary and/or tertiary)?**

....

....

2 **Are you a member of any medical associations? If yes, please specify.**

3 **What percentage of health funds are generated from:**

i) Government/public funding:	%
ii) Private Funding:	%
iii) Charitable donations:	%

4 **Are there any new changes or developments or activities to be carried out in the next 12 months? If Yes, please explain.**

5 **i) Are you licensed with the HPCSA?**

ii) Please state current number of CPD (Continuing Professional Development) points, and when they are due to expire?

iii) Have you been audited by the HPCSA in the past 24 months? If yes, did you meet all the necessary requirements

6 **Does the establishment have:**

	YES	NO
i) C.A.T and/or M.R.I scanner(s):		
ii) Medical teaching facilities:		
iii) Nursing teaching facilities:		
iv) Pathology laboratory:		
v) Any ambulances owned/operated:		

7 **Please specify:**

i) Total number of beds:	
ii) Average yearly occupancy:	
iii) Bassets/cribs/cots:	
iv) I.C.U units:	
v) Number of Operating theatres:	

8 **What percentage of patients admitted last year were from the USA/Canada?**

9 **i) Have all nurses under gone a CPR course?**

ii) How often are refresher CPR courses done?

10 Does the Hospital/Clinic have a blood bank?

11 Please provide full details of what records are kept and how they are stored and for how long they are retained.

12 Is patient confidentiality maintained at all times?

13 Does the Hospital/Clinic make use of electronic medical records? If yes, how is access to these electronic records restricted?

14 Is the patients consent obtained before carrying out any medical procedure or examination? Please provide a copy of your consent form.

15 Please specify number of babies delivered per annum:

16 In respect of neonatal care, what is the ratio of nurses to babies?

DECLARATION

Signing this proposal form binds neither the proposer to complete this insurance, nor does it bind the insurer to accept the proposal. It is agreed that all written statements and attachments furnished to the insurer in conjunction with this proposal are hereby incorporated by reference into this proposal and made part thereof. It is understood and agreed that the insurer has relied upon this proposal and attachments, which shall be the basis of the insurance contract.

The undersigned is an authorised signatory of the Proposer and certifies that reasonable inquiry has been made to obtain the answers herein which are true, correct and complete to the best of his/her knowledge and belief. We undertake to inform the insurer of any material alteration to these facts, whether occuring before or after completion of the insurance contract.

NAME ....

CAPACITY ....

SIGNATURE OF THE PROPOSER ....

DATE DD/MM/YYYY

BROKER DETAILS

Broker:	
Contact Person:	Tel:
Email:	Fax number: