Camargue
Specialised Liability Management

MEDICAL MALPRACTICE
MEDICAL PRACTITIONERS

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")

1 Proposer's Name: Date of Birth: / /

Identity number: Practice number (Pr.):

Incorporation details (if any)

VAT number (if any)

Practice address (main)

Postal Code:

Postal address (main) Postal Code:

Medical practitioner ("MP") registration number:

Name of institutions and number of years of membership with:

Date Company Established / Services Commenced: / /
As currently constituted

Contact Person: Contact number:

Email: Website:

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

2 **Please list the Licensing/Registration Body with which you hold a valid licence/membership:**

3 **a. Your registration number:**

b. Your registration date (DD/MM/YYYY):

c. Your registration type:

d. The date of your first registration (DD/MM/YYYY):

THE POWER OF KNOWLEDGE

4 **Please list the associations and any other relevant regulatory bodies or organisations with which you hold a licence or membership:**

5 **Has membership of or with any licensing body ever been:**

Refused		Suspended		Withdrawn		Had Conditions Imposed		None of the Above	

If any of the above are applicable, please provide detailed explanation(s) and any additional information that may be required in the supplementary section at the end of this Proposal Form (Section 6).

6 **Please confirm for which discipline(s) of medicine you require cover:**

Audiologist		Cardiologist		**Dentists***		Dermatologist	
Dietician		Endocrinologist		First Aider		General Practitioner	
Gynaecologist		Haematologist		Immunologist		Medical Lab Technician	
Microbiologist		Neurologist		Nuclear Medicine		Nurse	
Nutritionist		Occupational Therapist		Oncologist		Ophthalmologist	
Optometrist/Optician		Orthodontist*		Orthopaedics*		Paediatrician	
Paramedic		Pathologist		Perfusionist		Pharmacist	
Physiologist		Physiotherapist		Physicians		Prosthetist/Orthotist	
Psychiatrist		Radiographer		Radiologist		Sonographer	
Speech Therapist		Surgeon*		Urologist		Venereologist	
Other* (please specify)							

For all items marked with an asterisk (*), please provide further details in the supplementary information section (Section 8) and complete the required addendums found at the end of this Proposal Form.

7 **Are you in private practice, government employed (no private work) or government employed** (with private work)?

8 **If you are in private practice please confirm if you are a sole practitioner, in partnership, in association or practicing**

9 **Registered qualifications, dates and institutions at which they were obtained**

10 **Scope of Practice** (discipline and area of specialization, including any sub-specialty details)

11 **Do you perform any surgery?** If so, please specify the surgical procedures you perform the most & the % proportions

12 **Has any claim or complaint ever been made against you or your practice, including those notified to any other insurer or society?** If so, please confirm the type of incident, year, patient name and outcome

13 **Have you ever been the subject of any disciplinary proceedings by the HPCSA, criminal prosecutions or inquest proceedings?** If so, please confirm the type of incident, year, patient name and outcome

14 **Are you aware, after due consideration, of any claims or complaints that may be made against you or your practice?** If so, please confirm the type of incident, year, patient name and outcome

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

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 **Please list all claims made against the proposer and all circumstances that could give rise to a complaint and/or claim during the past ten years.**

- *If no claims have been made, please state "None" in the first column of the below table.*
- *Should you require additional space, please use the supplementary section at the end of this Proposal Form* ***(Section 8).***

Claim / Complaint / Incident			
Status			
Date the claim was made			
Date the claim was notified			
Reserve amount			
Total value claimed and total value paid (if paid)			
Description / Nature of allegations			
Deductible			

2 **What steps have been taken to prevent a recurrence?**

5 | PRACTICE (quotation cannot be provided without this informaiton)

Annual Total:	**Number of Patients**	Annual gross taxable turnover **| previous financial year**	Annual gross taxable turnover **| current financial year**	Annual gross taxable turnover **| next financial year**
Private practice totals:				
Government practice				

6 | COMMENTS AND CHOICE OF INDEMNITY LIMIT

Choice of indemnity limit and inception date:	
Excess:	

7 | BANK DETAILS FOR DEBIT ORDER INSTRUCTION

Bank	
Branch name	
Branch code	
Account number	
Account type	
Payment frequency:	

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:

7 | SUPPLEMENTARY INFORMATION

Please use this space to record the answers to any questions for which you require additional space, noting the appropriate question number

8 | ADDENDUM – DENTISTS AND SURGEONS

Dentist Addendum

Area	Percentage Split	Area	Percentage Split
Aesthetics and Cosmetic Dentistry		Orthodontics	
Anaesthesia/Sedation		Surgical Periodontal Treatment	
General Dentistry		Other (please specify)	
Implantology		Other (please specify)	
Oral Surgery		Other (please specify)	

Surgeon Addendum

Surgery	Percentage Split	Surgery	Percentage Split
Bariatric		Spinal Surgery	
Cardiac		Surgery (Minor)	
Elective Cosmetic		Surgery (Intermediate)	
Elective TOP		Surgery (Major)	
Gender Reassignment		Other (please specify)	
Orthopaedic		Other (please specify)	