Camargue
Specialised Liability Management

MEDICAL MALPRACTICE
RETIREMENT HOMES AND FRAIL CARE

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:	Date of Birth: / /
ID number (if Sole Trader):	
Trading Name (if different from above)	
Physical Address:	
	Postal Code:
Practice/Trading Address/es if different from the above:	
Company Reg No:	VAT No:
Date Company Established / Services Commenced: ***As currently constituted***	/ /
Date Company Established / Services Commenced: ***As initially established:***	/ /
Contact Name:	Contact number:
Email:	Website:
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

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?**

5 | ACTIVITIES OF PROPOSER

1 Please state the discipline(s) in which the Proposer is engaged

2 State the name and address of the any subsidiaries of the Proposer, for which cover is requested, indicating the location, date of establishment and principal activity of each company.

Name of Subsidiary	Location	Date Established	Principal Activity

6 | STAFF COMPLIMENT

	No. of employees	
Administrative personnel:		
Beauticians/hairdressers:		
Dieticians:		
Medical doctors:		
Physiotherapists:		
Care workers		
Other physicians (please specify):		
Other (please specify):		
Nursing Staff		
i) Director of Nursing		
Name:		
Qualifications:		
Year(s) Obtained:		
ii) Number of Nurses:	**Full-time**	**Part-time**
Senior Registered		
Senior Enrolled		
Auxiliary / Nurse aides		
Student Nurses		
Other (please provide details)		

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 frail care / retirement home	R	R
Gross revenue relating to rentals / leases etc	R	R
Gross revenue from medical procedures / pharmacies or any other medical treatment	R	R
Gross revenue from any other source (provide details)	R	R

8 | GENERAL INFORMATION

1 FACILITIES

i) Please state total number of beds per each category below, where:
"Aged" shall mean a person who, in the case of a male, is 65 years of age or older and, in the case of a female, is 60 years of age or older.

"Semi frail or frail" shall mean an older person in need of 24 hour care due to physical or mental condition which renders him or her incapable of caring for himself or herself.

	Total number of beds
Aged (independent living units)	
Semi-frail	
Frail	
ii) **Annual occupancy rate:**	
Aged	
Semi-frail	
Frail	

iii) **Fall Prevention**
Please detail your fall prevention programme, with particular attention to the prevention of "slip and trip" falls (handrails, non-slip flooring etc)

iv) **Wandering Prevention**
Please detail measures taken to prevent elopement and wandering off of patients, in particular to patients with Alzheimer's disease and other such conditions of dementia.=

v) **Transportation facilities**

In the case of an emergency does the nursing / retirement home have adequate transport services which are available at all times?

Yes ☐ No ☐

2 RESIDENT PROFILES

i) **Age group**	**Number**
Under 50	
50-60	
Over 65	
ii) **Number of residents covered by private medical aid:**	
iii) Number of residents dependent on government/state medical services:	

3 MEDICAL SERVICES RENDERED

i) Please detail the protocols in place for the administering, dispensing and storage of medication:

ii) How often are residents' medication and/or treatment records reviewed by a pharmacist or adequately qualified physician?

iii) Describe the method used to prevent medication errors?

iv) Does the Proposer maintain accurate descriptive records of medical services rendered? Yes ☐ No ☐

v) Does the Proposer's facility accept young people with disabilities? Yes ☐ No ☐

4 EMERGENCY PROTOCOLS

i) Is there a doctor on call in case of an emergency? Yes ☐ No ☐

ii) Do all residents have direct access to a panic button in case of an emergency? Yes ☐ No ☐

iii) How close is the nearest clinic or hospital? Km

iv) Have adequate emergency procedures been implemented, and are they regularly tested? Yes ☐ No ☐

v) Do all staff regularly practice the necessary emergency drills (i.e. in case of fire)? Yes ☐ No ☐

5 SUB-CONTRACTED SERVICES

i) Are any services provided by the retirement or frail care facility sub-contracted? Yes ☐ No ☐

If YES, please specific which services.

ii) Do you require that these sub-contractors carry their own insurance?

9 | ADDITIONAL INFORMATION

i) Is there any further information that should be made known to the Underwriters in order that they may form a proper estimate of the risk? Yes ☐ No ☐

If Yes, please attach relevant brochures or publications, copies of contract conditions, or advise on a separate page.

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: