Camargue

AMBULANCE SERVICES **PROPOSAL FORM**

MEDICAL MALPRACTICE

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):

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

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:

a) Required an increased premium or imposed special terms? **YES** ☐ **NO** ☐

b) Refused to accept or renew any insurance for the body corporate **YES** ☐ **NO** ☐

c) Cancelled the insurance? **YES** ☐ **NO** ☐

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

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3 | REQUIRED COVER

1. State the LIMIT OF INDEMNITY and EXCESS required:

Limit:	R	R	R
Excess:	R	R	R

4 | PREVIOUS LOSSES/ EXISTING CIRCUMSTANCES

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

a) Give rise to a claim against the Proposer, any predecessor or any past or present Principal? **YES** ☐ **NO** ☐

b). Cause any loss to the Proposer, any predecessor or any past or present Principal? **YES** ☐ **NO** ☐

c) Otherwise affect the consideration of this proposal for insurance? **YES** ☐ **NO** ☐

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 Lloyd's and Compass Insurance Company Limited

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

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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):

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3. What steps have been taken to prevent a recurrence?

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4. Have you ever engaged in a similar activity under a different name? YES ☐ NO ☐

If Yes, then please provide full information.

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5 | ACTIVITIES OF PROPOSER

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

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6 | NAMES AND QUALIFICATION OF DIRECTORS/PARTNERS & KEY PERSONNEL

NAME IN FULL	POSITION	QUALIFICATIONS	DATE QUALIFIED

2. Are you a member of any professional organisation, or registered with any self regulating body? YES ☐ NO ☐

If Yes, please state:

a) Which
b) Period of membership/ registration

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3. Has membership or registration with such organisation/body ever been suspended, withdrawn, amended or declined or had any special conditions attached?

YES ☐ NO ☐

If Yes, then please provide full information.

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7 | STAFF COMPLIMENT

1. Fully Qualified and Trained Paramedics

NAME IN FULL	QUALIFICATIONS	PREVIOUS EXPERIENCE

2. Volunteer and/or Trainee Paramedics

NAME IN FULL	QUALIFICATIONS (IF ANY)	PREVIOUS EXPERIENCE (IF ANY)

3. Qualified Nursing Staff

NAME IN FULL	QUALIFICATIONS	PREVIOUS EXPERIENCE

4. a) Number of ambulances in operation:

b) Are these ambulances all fully equipped to handle any/all emergencies?

YES ☐ NO ☐

If No, please specify:

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c) Number of crewmembers per ambulance per category:

Fully trained/ qualified paramedics: .....

Volunteer/ trainee paramedics: .....

Qualified nursing staff: .....

d) The minimum qualification of ambulance crewmembers: .....

e) Number of rapid response vehicles in operation: .....

f) Number of crewmembers per vehicle per category::

Fully trained/ qualified paramedics: .....

Volunteer/ trainee paramedics: .....

Qualified nursing staff: .....

g) The minimum qualification of rapid response vehicle crewmembers: .....

h) Please state:

	AMBULANCES	RAPID RESPONSE VEHICLES
The approximate number of emergency calls per month		
The approximate number of routine trips to hospital, etc. per month		
The radius of operations		

i) Number of shifts and hours worked per shift of crewmembers, per category:

	AMBULANCES AND RAPID RESPONSE VEHICLES	
	NO. OF SHIFTS	HOURS PER SHIFT
Fully trained/qualified paramedics		
Trainee/volunteer paramedics		
Qualified nursing staff		

j) Is an air ambulance repatriation service maintained? **YES** ☐ **NO** ☐

If Yes, please state:

The territories in which you expect to operate: .....

The number of repatriations per annum: .....

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8 | FINANCIAL INFORMATION

1. **When was your immediate past financial year end:** .....

	LAST YEAR	CURRENT YEAR ESTIMATE	FORTHCOMING FINANCIAL YEAR
Gross Revenue from Fees:	R	R	R
Gross Revenue from any other source (provide brief details on a separate page)	R	R	R
Total Revenue:	**R**	**R**	**R**

9 | ADDITIONAL INFORMATION

1. **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.

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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:

THE POWER OF KNOWLEDGE