Camargue

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

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 ☐

If Yes, please provide details:

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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

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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5 | ACTIVITIES OF PROPOSER

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

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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

Who requires coverage under this insurance policy:

	EMPLOYED		SELF EMPLOYED	
	HEADCOUNT	FTE	HEADCOUNT	FTE
Administrative personnel:				
Beauticians/hairdressers:				
Dieticians:				
Medical doctors:				
Physiotherapists:				
Care workers:				
Other Physician (please specify):				

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	EMPLOYED		SELF EMPLOYED	
	HEADCOUNT	**FTE**	**HEADCOUNT**	**FTE**
Other (please specify):				
Nursing staff				
a) Director of Nursing:				
Name:				
Qualifications:				
Year(s) Obtained:				
b) Number of Nurses:				
Senior Registered:				
Senior Enrolled:				
Auxiliary / Nurse aides:				
Student Nurses:				
Other (please provide details):				

1. **Do you require all employed and contracting physicians to maintain appropriate registration and licencing throughout the period of insurance, and do you require that they are members a defence organisation?** **YES** ☐ **NO** ☐

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

Sub Acute Care

Ventilator care, wound management, post-operative/trauma recovery, intravenous antibiotic &/or hydration therapy, spinal cord/ head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis.

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Frail Care

Professional nursing care, 24 hours, by licensed nurses. Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services.

Intermediate Care

Nursing care during day shift, 7 days per week, by licenced nurses. No complex nursing care (IVs, tube feeding, etc.). Administration of oral medications. Assistance with activities of daily living (i.e., walking, baths, dressing, eating), restorative rehabilitation. Some assistance with administering medications.

Alzheimer's Care

Residents have some degree of Alzheimer's or dementia.

Semi Frail Care

Residents are mobile with possible minor disorders – incidental health care services available are designed for persons who are mostly able to care for themselves. Provides protected environment, meals, assistance with medications and planned programs (such as group socials and spiritual activities, etc.).

Independent Living

Independent Living Services Residents are at retirement age and in general good health; occupy apartment/dwelling units that normally include cooking facilities. Residents do not receive any routine/planned health care services and administer own medication, but have access to health care services within the same facility complex. Full time caretaker on premises.

a) Please state total number of beds per each category below, where:

	BEDS	AVERAGE OCCUPANCY
Sub Acute Care:		
Frail Care:		
Intermediate Care:		
Alzheimer's Care:		
Semi Frail Care:		
Independent Living:		

b) Please state the number of separate locations, if any:

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c) Fall Prevention

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

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d) WanderingPrevention

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.

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e) 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

a) Age group	**Number**
Under 50	
50-60	
Over 65	
b) Number of residents covered by private medical aid:	
c) Number of residents dependent on government/state medical services:	
d) Number of residents outside the SADAC region:	

3. MEDICAL SERVICES RENDERED

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

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

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c) Does the Proposer maintain accurate descriptive records of medical services rendered? **YES** ☐ **NO** ☐

d) Does the Proposer's facility accept young people with disabilities? **YES** ☐ **NO** ☐

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4. EMERGENCY PROTOCOLS

a) Is there a doctor on call in case of an emergency? YES ☐ NO ☐

b) Do all residents have direct access to a panic button in case of an emergency? YES ☐ NO ☐

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

d) Have adequate emergency procedures been implemented, and are they regularly tested? YES ☐ NO ☐

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

5. SUB-CONTRACTED SERVICES

a) Are any services provided by the retirement or frail care facility sub-contracted? YES ☐ NO ☐

If YES, please specific which services.

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b) Do you require that these sub-contractors carry their own insurance? YES ☐ NO ☐

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9 | ADDITIONAL INFORMATION

a) 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