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MEDICAL MALPRACTICE PROPOSAL FORM

Individual Practitioner cover (Allied HC & Other Non-Invasive Practitioners)

Please Note: This is a proposal only, it is not binding until discussed with ourselves and accepted by you.

Important: In confirming this information, you must disclose all material facts. Failures to do so could invalidate the insurance or affect the premium.

| GENERAL | | | |
|---|--------|----------------------------------|--|
| Name of your Practice / Trading name | | | |
| Please note that this proposal form is an application to cover you as a sole/individual practitioner . If you wish for the practice and all employees to be covered, do contact us to discuss BEFORE completing this form. | | | |
| Title: | | Surname: | |
| Name: | | | |
| E-mail address: | | | |
| Cell Phone No: | | Fax Number: | |
| Practice Phone No: | | Renewal Date: | |
| Postal Address: | | | |
| | | Post Code: | |
| Physical Address: | | | |
| | | Area Code: | |
| ID Number: | | Vat No if applicable: | |
| Are you registered with the HPCSA or AHPCSA? (Please note that this is a prerequisite for obtaining insurance with any Insurer) | YES/NO | Medical Council Registration No: | |
| SANATA Membership Number | | | |

PLEASE WRITE THE CORRECT ANSWER FOR ALL QUESTIONS INCLUDING YES/NO QUESTIONS. DO NOT TICK OR CIRCLE THE CORRECT ANSWER. PLEASE NOTE THAT ALL QUESTIONS MUST BE ANSWERED OR IT MUST BE WRITTEN 'NOT APPLICABLE' OR N/A

If you work in both the state and in your private capacity, please ensure you complete the forms and specify what is done in what capacity.

PROFESSIONAL DETAILS

1.1 Please list your Qualifications, University/College attended and year obtained:

DEGREE 1: _____ UNIV/COLLEGE: _____ YEAR: _____
 DEGREE/DIPL 2: _____ UNIV/COLLEGE: _____ YEAR: _____
 DEGREE /DIPL 3: _____ UNIV COLLEGE: _____ YEAR: _____

Please confirm which disciplines(s) of therapy **you are qualified and licenced to practice:**

| | | | |
|---------------|--|------------------------|--|
| Music Therapy | | Drama Therapy | |
| Art Therapy | | Dance Movement Therapy | |

Other: _____

1.2 What is your area of Practice and Speciality (if applicable): _____

1.3 How long have you been in Practice? _____

1.4 Do you ever employ locums to assist you at your practice? YES/NO: _____

If yes, kindly ensure that all locums have their own Medical Malpractice policy as their activities will not be covered in terms of your policy. **Locum Definition:** A person who stands in temporarily for someone else of the same profession e.g. when ill or off for a short period.



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1.5 Are you a member of any other professional organization or society? If yes, please supply names of the organization(s) or society(ies)

1.6 Are you currently in a partnership?

YES/NO _____

****Do all of your partners carry their own medical malpractice insurance cover?**

YES/NO _____

****Does your partnership (practice) carry its own cover as an entity?**

YES/NO _____

NB: Please note that if you wish for claims made against the business to be covered, please ensure that you request this cover. In some cases you will need to complete a separate proposal form for the business entity.

PREVIOUS INSURANCE AND CLAIMS HISTORY

2.1 Have you had any Medical Malpractice Insurance before?

YES/NO _____

2.2 Please give the name of all organizations and the date which you were a member or a policy holder?

2.3 Have there been any gaps in your Medical Malpractice Insurance, including renewal, or been offered limited or conditional terms?

YES/NO _____

**** Where the answer is yes to the questions below, please supply a brief summary on a separate sheet including the date, the nature of the claim, any amounts paid by insurers, any amounts outstanding****

2.4 Have you ever been refused this type of Insurance or have you ever been asked to leave this type of Insurance or Organisation?

YES/NO _____

2.5 Have you had any claims or are you aware of any incidents or losses that could give rise to a claim on your Medical Malpractice Insurance (past 10 years)?

YES/NO _____

2.6 If so, have you notified or has your previous/current insurer been notified?
(Again, please supply a brief summary on a separate sheet).

YES/NO _____

2.7 Have you ever been the subject of a disciplinary enquiry by your employer or had practice privileges Refused / withdrawn or made conditional by a private health provider?

YES/NO _____

2.8 Have you ever been the subject to any complaint, enquiry, investigation or hearing by the HPCSA/AHPCSA or had conditions imposed on your practice or been suspended or erased from a medical register?

YES/NO _____

2.9 Have you ever been charged or cautioned by the police in respect of any criminal allegation?

YES/NO _____

2.10 Are there any other issues relating to your professional conduct or competence of which insurers might reasonably need to be aware of when considering your application for insurance?

YES/NO _____

MEDICAL MALPRACTICE – ALL MEDICAL PRACTITIONERS

IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS BELOW, PLEASE PROVIDE FURTHER DETAILS INCLUDING PERCENTAGE OF INCOME GENERATED IN THAT AREA OF WORK, IN AN ADDENDUM TO THIS PROPOSAL FORM.

3.1 DO YOU PERFORM:

- | | | | |
|----------------------------------|---------------|--------------------------------|---------------|
| a. Intravenous Therapy: | YES/NO: _____ | b. Dry needling: | YES/NO: _____ |
| c. Injections: | YES/NO: _____ | d. Botox or Filler Injections: | YES/NO: _____ |
| e. Any other form of Aesthetics: | YES/NO: _____ | f. Any form of Laser Work: | YES/NO: _____ |
| g. Procedures: | YES/NO: _____ | | |



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h. Do you provide any treatment to, or perform any work on animals: YES/NO: _____
i. If applicable to your profession, do you offer classes e.g. group therapy YES/NO: _____
Please indicate the maximum amount of patients you would have in any one class _____

3.2 Do you perform any work that is outside the scope of a regular professional in your field eg: Sports Event work, Clinical Trials etc? YES/NO: _____

3.3 Do you perform any treatments outside of South Africa? If yes, please supply details. YES/NO: _____

3.4 Do you conduct internet consultations with patients / online therapy: YES/NO: _____ If YES please advise on the following:

- a) What platform is used: _____
b) What percentage of your work pertains to online therapy: _____

3.5

| | R1 000 000 | R2 500 000 | R5 000 000 | R10 000 000 |
|--|------------|------------|------------|-------------|
| Please indicate which limit of indemnity you require quotations for: | | | | |

3.6 What is your **ANNUAL Gross FEE INCOME from PRIVATE work** (this includes hospital work done where the service is provided as an independent contractor)? **(This question MUST be answered for ALL applicants)**

3.7 What is your **ANNUAL Gross FEE INCOME from STATE work** (where you are employed by the state)? **(This question MUST be answered for ALL applicants)**

3.8 If employed in the public health sector, can you confirm that the state covers you for the work done for the state, YES/NO: _____

Or would you need this policy to include your state work? YES/NO: _____

3.9 Do you do any Medico-Legal Work? YES/NO: _____

Medical Malpractice Insurance covers errors and omissions arising out of your professional practice and includes Disciplinary Hearing Costs up to the Sum stated in the policy wording.

All medical malpractice policies are underwritten on a "Claims Made" basis. This means that:

- In order for a claim to qualify for Indemnity a policy must be in force when the claim is first made against the Insured. In terms of the policy conditions you are obliged to notify insurers as soon as you become aware of any circumstance which may lead to a claim. Any actual claim which then materializes would be deemed to be a claim under the policy which was in force at the time when the circumstance was first notified.
- The cause of action giving rise to the claim must either be on or after the 'retroactive date' shown in the Schedule of the policy.
- If the policy has lapsed there will be no cover notwithstanding the fact that the policy may have been in force at the time of the cause of action arose giving rise to the claim. It is therefore important to renew the policy annually. If the practice ceases it is recommended that run-off cover be taken for a minimum of three years.
- The policy is an annual policy and is non-cancellable and will run for a period of 12 months from inception / renewal.

*****Have you read and understood the explanation above regarding a claim made basis policy? _____**

I/ We declare and warrant that after enquiry all statements and particulars contained in this proposal and agenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters as soon as possible. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I / We hereby agree and accept that this declaration shall be the basis of the contract between both parties if entered in to.

I/We agree to read through the policy wording and if I do not understand any of the content, to contact YiB for further explanation

Name of Proposer _____

Signed _____ Date _____

Any further Instructions or Comments: