PI & LIABILITY UNDERWRITING MANAGERS

A C and E PI & Liability Underwriting Managers (Pty) Ltd

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P O Box 752189, Gardenview, 2047, Republic of South Africa
Company Registration Number: 2013/145635/07
VAT Registration Number: 4090266018

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Licensed Financial Service Provider 45553

PROPOSAL FORM
PROFESSIONAL INDEMNITY / MEDICAL MALPRACTICE INSURANCE FOR HEALTHCARE PROFESSIONALS

CAUTIONARY NOTE

Please answer all questions FULLY in order for us to correctly assess the risk and provide the most reasonable quotation. Furthermore, this Proposal Form will be read in conjunction with the Brokers Notes to Underwriters.
Failure to answer all applicable questions accurately could result in a claim being rejected due to a non-disclosure of material information.
Signature of this Proposal does not bind the Proposer / Insurers to complete the Insurance.

POLICIES ARE ISSUED AND ACCEPTED ON A 'CLAIMS MADE' BASIS

The policy will only respond to claims and/or circumstances, which are first made against the Insured and notified to the Insurer during the policy period. The policy will not provide cover for: -

- ***Events that occurred prior to the retroactive date of the policy.***
- ***Claims made after the expiry of the policy period even though the act giving rise to the claim may have occurred during the policy period.***
- ***Claims notified and/or arising out of facts and/or circumstances notified under any previous policy or noted on the current proposal form or any previous proposal form.***
- ***Claims made, threatened or intimated prior to the commencement of the policy period.***
- ***Facts or circumstances of which you are aware, prior to the policy period, whether or not they have the potential to give rise to a claim under the policy.***

1. **Name of Insured:**

   _____

2. **Main Office Physical Address:**

   _____

   _____

   Telephone: _____ **Fax:** _____

   Email: _____ **Website:** _____

3. **Postal Address:**

_____

_____

4. **Location of Branch Offices:**

_____

_____

_____

_____

_____

5. **Number of employees:**

_____

(i) **On a separate sheet please indicate staff compliment by, (a) Number of employees and (b) designation/position of the employees**

(ii) **Professional employees please indicate (a) Academic Qualification and (b) experience**

6. **Company Registration No.:**

_____

7. **Company VAT No.:**

_____

8. **Date company established:** _____

9. **Previous name(s) of company (if applicable):** _____

10. **Details of Professional Bodies to which the firm belongs** _____

_____

_____

11. **(i) In what AREA or branches of ALLIED HEALTHCARE medicine are you qualified and, if applicable, licensed to practice?**

AMBULANCE ASSISTANT	___	ORTHOTIST/ PROSTHETIST	___
AUDIOLOGIST/ SPEECH THERAPIST	___	PARAMEDICS	___
BIOKINETICIST	___	PARAMEDIC ORGANISATION	___
CARE GIVERS	___	PERFUSIONIST	___
DENTAL TECHNICIAN	___	PODIATRIST	___
DIETITIAN	___	PSYCHOLOGIST (Clinical/Other)	___

MEDICAL PHYSICIST	___	PSYCHOLOGIST (Industrial/Org)	___
MEDICAL TECHNOLOGIST	___	RADIOGRAPHER	___
NURSE (PRIVATE HOSPITAL EMPLOYED)	___	SEXOLOGIST	___
NURSE (PRIVATE PRACTITIONER)	___	SONOGRAPHER	___
NURSE (STATE HOSPITAL EMPLOYED	___	SPORT SCIENTIST	___
OCCUPATIONAL THERAPIST	___	OPTOMETRIST	___
ORAL HYGIENEST / DENTAL THERAPY	___		
NURSE IN PATH LAB OR WOUNDCARE ONLY	___		
NURSE IN PATH LAB OTHER	___		

Other (Please specify):

_____

_____

(ii) On separate sheet please indicate <u>any general information</u> for your specific professional activities, making reference to but not

Limited to the below list and include any further information that should be made known to Underwriters:

(a) Risk management including Emergency Protocol and fall prevention management if relevant to your Profession;

(b) Resident Profile / Accommodation including number of beds per category and age where applicable and if relevant to your profession

(c) Medical Services rendered

12. Does any person involved in treatment and care of any patient suffer from any disability, transmittable diseases i.e. Hepatitis, H. I. V. etc or other impediment which may affect the performance of his / her professional duties or place patients / clients at risk?
Yes / No

If 'YES' what procedures are in place?

_____

_____

13. Has the Proposer or any employee involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries?

Yes/No **If 'YES' please give full details:**

_____

_____

14. If you are an employee, is it a condition of your employment that you maintain Medical / Professional Liability Insurance?

Yes / No

15. **Legal Constitution: cc; sole trader; private company; public company;**

16. **Annual Turnover:**

Date of financial Year end: _____

Past Actual Turnover: _____

Estimated Annual Turnover: _____

17. **Percentage of business conducted outside the Republic of South Africa: _____%**

List the countries:

____

18. **Are you at present or have you in the past been insured for Professional Liability: _____**

***If yes, please provide the following details*:**

Name of Insurers:

_____

Date cover expires/d:

_____

Expiry of "Run-off" cover (if any): _____

Limit of Liability: _____

Excess applicable: _____

Premium applicable: _____

19. **Has any application for insurance of this nature (made on behalf of the Company or their predecessors in business or by any of the present partners) ever been declined or cancelled, or has renewal been refused or have special terms been imposed?**

Yes / No

If yes, please supply details:

_____

_____

20. During the last five years:

(i) Has the company had any loss and if so, please give full details of the loss:

_____

_____

(ii) Aware of any circumstance/incidents which might give rise to a claim against the Proposer, any predecessor or any past or present Principal, please give full details herein:

_____

_____

(iii) Aware of any circumstance/incidents which might cause any loss to the Proposer, any predecessor or any past or present Principal, please give full details herein:

_____

_____

(iv) Aware of any circumstance/incidents which might otherwise affect the consideration of this proposal for insurance, please give full details herein:

_____

_____

21. Retroactive Date Required:

_____

22. Please supply any additional information pertinent to products manufactured / sold and or services provided (on separate sheet or supply brochures).

_____

Cover required:

	Limit of Indemnity any one occurrence	Annual Aggregate	Self-Insured Excess per Occurrence
Professional Indemnity / Medical Malpractice			
General Liability			
Products Liability			

DECLARATION

I/ we hereby declare that the statements and particulars in this application are true and complete and that at the present time, other than stated above, I/we have no reason to anticipate any claim being brought against me / us, that might constitute a claim under the insurance now being requested. I / we agree that this Proposal and Declaration be the basis of the contract between me/us and the Insurers.

_____ _____

Signature of the Proposer **Date**

_____ _____

Name of Proposer (Please print) **Capacity of the Proposer**