



The Liability Company.

LIABILITY MATTERS

Medical Malpractice Insurance Proposal Form

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

- Events that occurred prior to the retroactive date of the policy (if specified).
- Claims made after the expiry of the policy period even though the Wrongful Act giving rise to a claim may have occurred during the policy period.
- Claims notified or arising out of facts or circumstances notified under any previous policy or noted on the current proposal form.
- Claims made, threatened or intimated prior to the commencement of the policy period.
- Facts or circumstances in your knowledge prior to the policy period, which you know had the potential to give rise to a claim under the policy.

Disclosure

You must disclose to the Insurer all information which is material to it in deciding whether to issue insurance cover to you, including any facts or conduct which might lead to a claim being made against you. Failing to do so could affect your rights to indemnity.

If you do not understand any part of this document, please contact your broker before you sign it. You will be bound by the answers which are given, and by the information provided by you in the proposal form. It is in your interest to make sure that all information is properly understood. If you are in any doubt, discuss the issue with your broker or disclose the information to the Insurers.

Attachments

Before you return this form, have you included the following (please indicate yes or no)

Copy of most recent policy schedule

Curriculum Vitae

Five-year claims History

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

The Liability Company (Pty) Ltd

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The Liability Company is an authorised financial services provider (FSP 50828)

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Underwritten by:

MUTUAL & FEDERAL | risk financing
A member of the  **OLD MUTUAL** Group

1. Client information

Name of applicant

2. Address and contact details (include branches to be covered if relevant)

Address

Address

Suburb

Suburb

Postal code

Postal code

Phone number

Phone number

Email

3. Educational background

Name of Medical School

Address of institution

Degrees/Diploma/Other

Year completed

Degrees/Diploma/Other

Year completed

If Graduate of a Foreign Medical School – Name of Medical School

Address of institution

Residency training

Locations local and foreign

4. Policy information

Name of current insurer

Number of years with Current Insurer

Existing Form of Insurance

Occurrence

Claims made

If claims-made, did you purchase an extended reporting endorsement from your current Insurer?

Yes No

Current Policy Period

Current Policy Limit of Indemnity

R

Retroactive Date

Note – Include a copy of the existing policy schedule

5. Cover required (only claims made policy wording is available)

Limit of Indemnity required?

Are you applying for prior acts coverage?

 Yes No

If yes, what limit of indemnity do you require for the prior acts coverage?

Effective date of coverage applied for?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

6. Practice information

Practice name

Practice number

VAT number

Type of Practice

Individual

Employee

Partner

Intern-Resident

Owner

Other

To which Medical Associations do you belong?

Present Speciality

Sub-Speciality such as Anaesthesiology

What percentage of your practice is devoted to your speciality?

Speciality

%

Sub-Speciality

%

7. Patients

How many scheduled patients do you see per week?

How many walk-in patients do you see per week?

How many hours do you work per week?

8. Change in Practice/Speciality

Has there been any change in your practice or speciality in the past five years?

 Yes No

When did this occur?

Are you permanently retired from the practice of clinical medicine?

 Yes No

Medical Council Certified?

 Yes No

Speciality Board Certified?

 Yes No

9. Hospitals where you practice (list principle location first)

Name of Hospital (A)

Name of Hospital (B)

Types of Privileges

Types of Privileges

Percentage of Practice

%

Percentage of Practice

%

Name all the places where you have practiced your profession in the last five years if different to locations above

Name of Hospital (A)

Name of Hospital (B)

Types of Privileges

Types of Privileges

Percentage of Practice

%

Percentage of Practice

%

10. Rating information – Indicate percentage of time devoted to the following medical and/or surgical activities. Total should equal 100%

Abdominal Surgery	%	Neurosurgery	%
Aerospace Medicine	%	Nuclear Medicine	%
Allergy	%	Nutrition	%
Anaesthesiology	%	Obstetrics/ Gynaecology	%
Broncho-Esophagology	%	Occupational Medicine	%
Cardiac Surgery	%	Ophthalmology	%
Cardiovascular Diseases	%	Optometrist	%
Colon and Rectal Surgery	%	Orthopaedic Surgery – All limbs	%
Dermatology	%	Orthopaedic Surgery - Lower limbs	%
Diabetes	%	Orthopaedic Surgery - Upper limbs	%
Emergency Medicine	%	Osteopathy	%
Endocrinology	%	Otology	%
Family Practice	%	Otorhinolaryngology	%
Forensic Medicine	%	Paediatrics	%
Gastroenterology	%	Pathology	%
Neurology	%	Peer Reviews	%
General Practice	%	Physical Medicine	%
General Preventative Medicine	%	Plastic - Otorhinolaryngology	%
General Surgery	%	Plastic Surgery	%
Geriatrics	%	Podiatry	%
Gynaecology	%	Psychiatry	%
Haematology	%	Psychosomatic Medicine	%
Hand Surgery	%	Public Health	%
Head and Neck Surgery	%	Pulmonary Disease	%
Hypnosis	%	Radiology	%
Infectious Diseases	%	Rehabilitation	%
Intensive/ Critical care medicine	%	Rheumatology	%
Internal Medicine	%	Rhinology	%
Laryngology	%	Thoracic Surgery	%
Legal Medicine	%	Traumatic Surgery	%
Neoplastic Diseases	%	Urology	%
Nephrology	%	Vascular Surgery	%

11. Do you perform (please tick all the boxes that apply)

- Category 1 No surgery procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia or circumcision.
- Category 2 Perform minor surgery or assist in surgery on your own patients.
- Category 3 All other types of surgery and procedures performed under general anaesthesia and assisting in surgery on other than your own patients.
- Category 4 Obstetrics including normal deliveries and C-sections.

12. Please tick the following medical techniques or procedures you perform

Abdominal Surgery	<input type="checkbox"/>	Gastric stapling	<input type="checkbox"/>
Abortions	<input type="checkbox"/>	Haemorrhoidectomies	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	Herniorrhapies	<input type="checkbox"/>
Administer or supervise anaesthesia	<input type="checkbox"/>	Hysterectomies	<input type="checkbox"/>
Amniocentesis	<input type="checkbox"/>	Injection of irradiated substances into the blood stream for diagnostic purposes (IVPs)	<input type="checkbox"/>
Angiography	<input type="checkbox"/>	Laser used in therapy	<input type="checkbox"/>
Appendectomies	<input type="checkbox"/>	Liposuction	<input type="checkbox"/>
Arterial	<input type="checkbox"/>	Plastic and cosmetic procedures	<input type="checkbox"/>
Aspirations	<input type="checkbox"/>	Laparoscopic cholecystectomies	<input type="checkbox"/>
Back surgery	<input type="checkbox"/>	Laparoscopy (peritoneoscopy)	<input type="checkbox"/>
Bariatric surgery	<input type="checkbox"/>	Laparoscopic laser surgery	<input type="checkbox"/>
Botox injections	<input type="checkbox"/>	Lumber puncture	<input type="checkbox"/>
Breast implants	<input type="checkbox"/>	Lymphangiography	<input type="checkbox"/>
Cardiac catheterization	<input type="checkbox"/>	Needle biopsy	<input type="checkbox"/>
Cardiac surgery	<input type="checkbox"/>	Neo-natal intensive care visits	<input type="checkbox"/>
Cast (set)	<input type="checkbox"/>	Phlebography	<input type="checkbox"/>
Cholecystectomies	<input type="checkbox"/>	Pyelography	<input type="checkbox"/>
Circumcisions (other than new-born)	<input type="checkbox"/>	Nerve blocks	<input type="checkbox"/>
Closed reduction of fractures	<input type="checkbox"/>	Open reductions	<input type="checkbox"/>
Colonoscopies	<input type="checkbox"/>	Orthopaedic surgery	<input type="checkbox"/>
Cosmetics	<input type="checkbox"/>	Pnuemoencephalography	<input type="checkbox"/>
Cranial surgery	<input type="checkbox"/>	Pre-natal care past first timers	<input type="checkbox"/>
Cryosurgery on malignant lesions	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>
C-sections, per month	<input type="checkbox"/>	Reconstruction	<input type="checkbox"/>
CT scanning with dye	<input type="checkbox"/>	Sedation analgesia or conscious sedation	<input type="checkbox"/>
CT scanning without dye	<input type="checkbox"/>	Surgery (other) - please specify	<input type="checkbox"/>
Deliveries, per month	<input type="checkbox"/>		<input type="checkbox"/>
Diagnostic coronary angiography	<input type="checkbox"/>		<input type="checkbox"/>
Dilation and curettage	<input type="checkbox"/>		<input type="checkbox"/>
Discography	<input type="checkbox"/>	Shock therapy (ECT/EST)	<input type="checkbox"/>
EKG stress test	<input type="checkbox"/>	Skin flap/grafts	<input type="checkbox"/>
EGD	<input type="checkbox"/>	Thoracic surgery	<input type="checkbox"/>
Endoscopies (please specify)	<input type="checkbox"/>	Tonsillectomies	<input type="checkbox"/>
	<input type="checkbox"/>	Trauma surgery	<input type="checkbox"/>
Flexible sigmoidoscopies greater than 60cm	<input type="checkbox"/>	Tubal ligations	<input type="checkbox"/>
Fluoroscopic procedures	<input type="checkbox"/>	Vascular surgery	<input type="checkbox"/>
Gastric bubble	<input type="checkbox"/>	Vasectomies	<input type="checkbox"/>

13. Answer the following questions with Yes or No

Do you normally staff an emergency room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you employed full time by the Government or are you in military service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you engaged in "moonlighting" activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, number of hours per month spent moonlighting	<input type="text"/>	
Do you own or operate a surgical centre, emergency facility, minor emergency care facility, laboratory, or other outpatient facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any hospital ever denied, restricted, suspended or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have your narcotics or medical license ever been suspended, restricted, revoked or voluntarily surrendered, or has probation ever been invoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental health? Marriage counselling after divorce	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been asked to participate in or have you volunteered to participate in an impaired physician program? (If yes, please attach a copy of your recovery plan)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, was your participation	<input type="checkbox"/> Mandatory	<input type="checkbox"/> Voluntary
Have you ever been denied a medical license or been denied certification by specialty board? (Local or Foreign)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you do outside peer reviews or medical exams, or have a contract with an insurance company to do reviews?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, what percentage of practice	<input type="text"/> %	
Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO, or any governmental agency or program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you provide any diagnostic, consulting, or other professional services to patients in provinces other than those in which you are currently licensed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a request for coverage denied, your policy cancelled or non-renewed or had a policy issued to you that contained restrictions or special exclusions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a claim of sexual misconduct against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you performed and/or do you currently perform silicone breast implants? (If yes, describe the types and time frames in which they were performed. Confirm compliance with Medical board recommendations regarding silicone breast implants.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the past twelve months, have you had any injury, illness or other event occur that may impair, lessen or diminish your physical or mental ability to practice your speciality?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a patient or their representative ever filed a complaint or grievance against you with a hospital committee, or regulatory body or other medical review committee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any claims or suits ever been made or brought against you whether settled out of court or not?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indicate number of previous claims or suits (include closed, dismissed, and/or dropped cases)	<input type="text"/>	
Indicate number of pending claims or suits.	<input type="text"/>	

Note – Attached claims information must be completed for each case indicted

Claims made

Medical Malpractice insurance policies are underwritten on a "Claims Made" basis. This means that;

1. In order for a claim to qualify for indemnity a policy must be in force when the claim is first made against you. (In terms of the policy conditions you are obliged to notify Insurers as soon as you become aware of any circumstances which may lead to a claim. Any actual claim which then materialises would be deemed to be a claim under the policy which was in force at the time when the circumstance was first notified).
2. The cause of action giving rise to the claim must have taken place on or after the "retro-active date" shown in the Schedule of the policy.
3. If the policy has lapsed there will be no cover notwithstanding the fact that the policy may have been in force at the time when the cause of action occurred 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.

Retro-Active date

The date on or after which any claim against you will be indemnified in terms of the policy. This date is normally fixed as being the date on which the cover was first taken and would remain unaltered for the purposes of subsequent renewals. When cover is first taken additional retro-active cover may be offered by Insurers subject to certain conditions and premium loadings.

Declaration

I/We declare that the statements and particulars in this proposal are true and that I/ We have not misstated or suppressed any material facts. I/We agree that this proposal, together with any other information supplied by me/ us shall form the basis of any contract of insurance effected thereon. I/ We undertake to inform the Insurers of any material alteration to these occurring before/ during/ after completion of the Contract of Insurance.

Signed at _____ dated _____

Full name _____

Signature _____

Cooling Off Rights

You enjoy a period of 14 (Fourteen) days ("cooling-off period") from receipt of the Policy document following the inception date of the insurance agreement if taken or from the effective date of any variation thereof, during which you may rescind the agreement and provided that you have not claimed any benefit, are not in receipt of a claim made against you or reported any claim to the Insurer, the insurance agreement is annulled and you will be entitled to a refund of Premium paid.

The Insurer will give effect thereto and return premiums due to you less an administration charge within 30 (Thirty) days of the annulment.

Claims Information (please complete this section for each previous and pending claim against you)

Patient's name _____

Date reported to insurance company

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Any possible claim not yet reported to your insurer _____

Name of insurance company _____

Date of incident

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Treatment _____

Was the patient referred to you for remedial surgery? _____

If yes, by whom? _____

Allegations _____

Did you in any way alter, embellish, delete, change and/or destroy any records, medial or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

Status of claim (tick where appropriate)

Suit threatened, no action taken

Suit filed but dropped by claimant

Summary judgement in your favour

Court outcome in your favour

Court outcome in favour of plaintiff

Amount of Award

R

Suit settled out of court

Date of incident

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Did you want to settle this claim? Yes No

Awaiting mediation Yes No

Awaiting court action

R

Reserve Amount

R

Signed at _____ dated _____

Full name _____

Signature _____

Claims Information (please complete this section for each previous and pending claim against you)

Patient's name _____

Date reported to insurance company

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Any possible claim not yet reported to your insurer _____

Name of insurance company _____

Date of incident

S	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Treatment _____

Was the patient referred to you for remedial surgery? _____

If yes, by whom? _____

Allegations _____

Did you in any way alter, embellish, delete, change and/or destroy any records, medial or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

Status of claim (tick where appropriate)

Suit threatened, no action taken

Suit filed but dropped by claimant

Summary judgement in your favour

Court outcome in your favour

Court outcome in favour of plaintiff

Amount of Award

R

Suit settled out of court

Date of incident

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Did you want to settle this claim? Yes No

Awaiting mediation Yes No

Awaiting court action

R

Reserve Amount

R

Signed at _____ dated _____

Full name _____

Signature _____

Claims Information (please complete this section for each previous and pending claim against you)

Patient's name _____

Date reported to insurance company

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Any possible claim not yet reported to your insurer _____

Name of insurance company _____

Date of incident

S	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Treatment _____

Was the patient referred to you for remedial surgery? _____

If yes, by whom? _____

Allegations _____

Did you in any way alter, embellish, delete, change and/or destroy any records, medial or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

Status of claim (tick where appropriate)

Suit threatened, no action taken

Suit filed but dropped by claimant

Summary judgement in your favour

Court outcome in your favour

Court outcome in favour of plaintiff

Amount of Award

R

Suit settled out of court

Date of incident

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Did you want to settle this claim? Yes No

Awaiting mediation Yes No

Awaiting court action

R

Reserve Amount

R

Signed at _____ dated _____

Full name _____

Signature _____