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	☐	**Yes**	☐	**No**
Curriculum Vitae	☐	**Yes**	☐	**No**
Five-year claims History	☐	**Yes**	☐	**No**

The Liability Company (Pty) Ltd
35 Oxford Office Park, 3 Bauhinia Street
Highveld Techno Park, Centurion
PO Box 17541, Lyttleton, Pretoria, Gauteng, 0140
The Liability Company is an authorised financial services provider (FSP 50828)

Our Risk Carriers
All our policies are underwritten by Old Mutual Insure Limited (FSP12) and Mutual & Federal Risk Financing Limited (FSP 49551) on a co-insurance basis. Both OMI and MFRF are authorised financial services providers of short term insurance products

Contact Us
T +27 (12) 667 2441
E info@theliabilitycompany.com
W www.theliabilitycompany.com

Underwritten by

OLDMUTUAL INSURE

MUTUAL & FEDERAL | risk financing

A member of the OLDMUTUAL Group

1. Client information

Name of applicant

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

Address

Suburb

Postal code

Phone number

Email

Address

Suburb

Postal code

Phone number

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 D D M M Y Y Y Y

Note – Include a copy of the existing policy schedule

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

Limit of Indemnity required? R

Are you applying for prior acts coverage? ☐ Yes ☐ No

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

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 ☐ Intern-Resident

☐ Employee ☐ Owner

☐ Partner ☐ 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)

Types of Privileges

Percentage of Practice %

Name of Hospital (B)

Types of Privileges

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)

Types of Privileges

Percentage of Practice %

Name of Hospital (B)

Types of Privileges

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

13. Answer the following questions with Yes or No

Do you normally staff an emergency room?	☐ Yes	☐ No
Are you employed full time by the Government or are you in military service?	☐ Yes	☐ No
Are you engaged in "moonlighting" activities?	☐ Yes	☐ No
If Yes, number of hours per month spent moonlighting		
Do you own or operate a surgical centre, emergency facility, minor emergency care facility, laboratory, or other outpatient facility?	☐ Yes	☐ 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?	☐ Yes	☐ No
Have your narcotics or medical license ever been suspended, restricted, revoked or voluntarily surrendered, or has probation ever been invoked?	☐ Yes	☐ 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	☐ Yes	☐ 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)	☐ Yes	☐ No
If yes, was your participation	☐ Mandatory ☐ Voluntary	
Have you ever been denied a medical license or been denied certification by specialty board? (Local or Foreign)	☐ Yes	☐ No
Do you do outside peer reviews or medical exams, or have a contract with an insurance company to do reviews?	☐ Yes	☐ No
If Yes, what percentage of practice	%	
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?	☐ Yes	☐ No
Do you provide any diagnostic, consulting, or other professional services to patients in provinces other than those in which you are currently licensed?	☐ Yes	☐ 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?	☐ Yes	☐ No
Have you ever had a claim of sexual misconduct against you?	☐ Yes	☐ 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.)	☐ Yes	☐ 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?	☐ Yes	☐ 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?	☐ Yes	☐ No
Have any claims or suits ever been made or brought against you whether settled out of court or not?	☐ Yes	☐ No
Indicate number of previous claims or suits (include closed, dismissed, and/or dropped cases)		
Indicate number of pending claims or suits.		

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 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 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 _____