The Liability Company.

LIABILITY MATTERS

Allied Healthcare Malpractice 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	☐ Yes	☐ No
schedule Curriculum Vitae	☐ Yes	☐ No
Five-year claims History	☐ Yes	☐ No

Underwritten by

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 Institution

Address of institution

Degrees/Diploma/Other **Year completed**

Degrees/Diploma/Other **Year completed**

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 _____ / __________ / 20_____ **To** _____ / __________ / 20_____

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 for Malpractice? R

Limit of Indemnity required for General Liability? R

Limit of Indemnity required for Products Liability? R

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

If yes, effective date of coverage applied for? | D | D | M | M | Y | Y | Y | Y |

6. Business information

Practice or studio name: ____________________

VAT number

Type of Practice / or Area of Allied Healthcare

Date established:

Date of financial Year End:

Past Actual Turnover:

Estimated current year Turnover:

To which Professional Body or Association do you belong?

____

Percentage of business conducted outside of South Africa %

List the countries: ____________________

7. **Rating information – Indicate percentage of time devoted to the following activities. Total should equal 100%**

Activity	%
Acupuncturists but excluding acupuncture related infection (including but not limited to HIV, Hepatitis, Bacterial etc)	%
Audiology and speech therapy Beauty and health spa therapy	%
Counsellors (mental health, family therapists)	%
Dental hygienists and dental assistants	%
Diagnostic medical personnel (medical laboratory scientists, histotechnologists and pathologists' assistants)	%
Dietitians (but not in the treatment of diabetes or metabolic diseases)	%
Emergency Medical personnel (EMT, paramedics)	%
Exercise science Professional (Personal trainers, yoga / pilates instructors, exercise physiologists, Kinesio therapists, bio kineticists)	%
Hairdressers / Stylists	%
Health educators (asthma educators, diabetes educators)	%
Health Information technologists	%
Homeopaths	%
Imaging specialists (radiographer (not including radiologists) and sonographers)	%
Nutrition (but not in the treatment of diabetes or metabolic diseases)	%
Occupational therapists	%
Optometrists (excluding ophthalmologists)	%
Pharmacy personnel (pharmacists, pharmacy technicians and assistants)	%
Physical therapists and massage therapists	%
Physician assistants but excluding registered nurses)	%
Psychologists (not psychiatrists)	%
Radiographer / Sonographer (excluding radiologists)	%
	%
	%
	%

Other (please specify)

9. Answer the following questions with Yes or No

Does any person involved in treatment and care of any client suffer from a disability, transmittable disease (e.g. Hepatitis, HIV or other impediment) which may affect the performance of his/her professional duties? ☐ **Yes** ☐ **No**

If 'Yes', what safety procedures are in place?

____

Has the applicant or any employee involved in the treatment or care of clients, 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 specify details:

____

If you are an employee, is it a condition of your employment that you maintain Medical / Professional Indemnity Insurance? ☐ **Yes** ☐ **No**

10. Claims:

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

If 'Yes' please supply details:

Has a patient or their representative ever filed a complaint or grievance against you with a regulatory body or other review committee? ☐ Yes ☐ No

If 'Yes' please supply details: 'Yes' please supply details:

If 'Yes' please supply details:

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

Claims made

Allied Health 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 materializes 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.