HOSPITALS AND CLINICS MEDICAL MALPRACTICE

PROPOSAL FORM

a. Answer all questions leaving no blank spaces
b. If you have insufficient space to complete any of your answers, continue on your headed paper.
c. It is the intention of Underwriters that any Contract of Insurance with the Proposer shall be based upon the answers and information provided by the proposer. If a quotation is offered it will be the intention of the Underwriters to offer coverage only in respect of those entities named in answer to Question 1.

A.	**PARTICULARS OF PROPOSER**			
1.	Name and full address details:			
	Telephone:			
	Fax:			
	E-mail:			
	Web Address:			
	Registration number:			
	VAT Registration number:			
	Date established:			
2.	State the name and address of the any subsidiaries of the Proposer, for which cover is requested, indicating the location, date of establishment and principal activity of each company.			
	Name of subsidiary	**Location**	**Date Established**	**Principal Activity**
3.	Present Legal constitution	**X**		
	i) Partnership			
	ii) Private Company			
	iii) Public Company			
	iv) Close Corporation			
	v) Non-profit Organisation			
	vi) Government			
4.	Please state the disciplines in which the Proposer is engaged.			

B.	STAFF COMPLIMENT			
		No. of employees	No. Self-Employed	No. of years of practising
	Anaesthesiology			
	Auxiliaries non-qualified			
	Auxiliaries nurses -qualified			
	Cardiac/Thoracic/Vascular Surgery			
	Cardiology			
	Dental Surgery/ maxilla-facial			
	Dentist/Orthodontist			
	Dermatology			
	ENT			
	General Practitioner			
	General surgery			
	Gynaecologists			
	Internal medicine			
	Lab/Pathology technicians			
	Neonatology			
	Neurology			
	Nurses:			
	i) Enrolled nurses			
	ii) Matron			
	iii) Midwives			
	iv) Nurse Anaesthetist			
	v) Registered nurses			
	vi) Student Nurses			
	Care workers			
	Obstetricians			
	Orthopaedic			
	Paediatrics			
	Paramedics			
	Pharmacists			
	Plastic surgery			
	Radiology			
	Residential Medical Officers			
	Urology			
	Directors/Partners/Principals			
	Administration			
	Other(please provide details)			
	Total			

C.	FINANCIAL INFORMATION		
	When was your immediate past Financial Year End:		
	Please state:	As at immediate Past Financial Year End	As at Previous Financial Year End
	Gross Revenue of the Hospital/Clinic	R	R
	Gross Revenue relating to Rentals/Leases	R	R
	Gross Revenue from medical Procedures/Pharmacies or any other Medical Treatment	R	R
	Gross Revenue from any other source (provide brief details).	R	R
	Total Revenue	R	R

D.	Claims Experience
1.	Have any claims ever been made against the proposed Insured/Partners/Directors/Members or Employees for the type of cover for which you are now applying?
2.	If yes, please provide full details (on a separate sheet) and confirm:
	i) Whether insured and the reserves held by the insurers:
	ii) The quantum of costs incurred:
	iii) Costs incurred:
	iv) Preventative measures taken:
3.	Are any of the Proposed Insured/Partners/Directors/ Members or Employees, after enquiry, aware of any circumstances which would be covered under a policy of this type that may result in any claims or a possible claim being made against them?
4.	If yes, please provide full details on a separate page
5.	Have you ever been subject to any disciplinary proceedings by the HPCSA, criminal prosecutions or inquest proceedings? If so, please provide full details.
6.	Are you aware, after due consideration, of any claims or complaints that may be made against you or your practice? If so, please provide full details.
7.	Is there any other information which you consider material to the risks to be insured that should be disclosed?

E.	INSURANCE HISTORY
1.	Are you at present or have you in the past been insured?

2.	If yes, please state:	
	Insurers:	
	Limit of Indemnity:	R
	Excess (Each and Every Claim):	R
	Premium:	R
	Date of expiry of coverage:	
	Retroactive Date:	
3.	For the type of Insurance now being proposed, has any Insurer ever:	
	i) Declined Proposal or renewal?	
	ii) Required an increased premium or imposed special terms?	
	iii) Cancelled the Insurance?	
	If any answer is **Yes** to any of the above 3 questions, please provide full details on separate page.	

F.	**GENERAL INFORMATION**	
1.	What level of healthcare is delivered (primary, secondary and/or tertiary)?	
2.	Are you a member of any medical associations? If yes, please specify.	
3.	What percentage of health funds are generated from:	
	i) Government/public funding:	%
	ii) Private Funding:	%
	iii) Charitable donations:	%
4.	Are there any new changes or developments or activities to be carried out in the next 12 months? If Yes, please explain.	
5.	i) Are you licensed with the HPCSA?	
	ii) Please state current number of CPD (Continuing Professional Development) points, and when they are due to expire?	
6.	iii) Have you been audited by the HPCSA in the past 24 months? If yes, did you meet all the necessary requirements	

7.	Does the establishment have:	
	i) C.A.T and/or M.R.I scanner(s):	
	ii) Medical teaching facilities:	
	iii) Nursing teaching facilities:	
	iv) Pathology laboratory:	
	v) Any ambulances owned/operated:	
8.	Please specify:	
	i) Total number of beds:	
	ii) Average yearly occupancy:	
	iii) Bassets/cribs/cots:	
	iv) I.C.U units:	
	v) Number of Operating theatres:	
9.	What percentage of patients admitted last year were from the USA/Canada?	
10.1	Have all nurses under gone a CPR course?	
10.2	How often are refresher CPR courses done?	
11.	Does the Hospital/Clinic have a blood bank?	
12.	Please provide full details of what records are kept and how they are stored and for how long they are retained.	
13.	Is patient confidentiality maintained at all times?	
14.	Does the Hospital/Clinic make use of electronic medical records? If yes, how is access to these electronic records restricted?	
15.	Is the patients consent obtained before carrying out any medical procedure or examination? Please provide a copy of your consent form.	
16.	Please specify number of babies delivered per annum:	
17.	In respect of neonatal care, what is the ratio of nurses to babies?	

G.	**REQUIRED COVER**			
1.	State the Limit of Indemnity and Excess required:			
	Limit/s:	R	R	R
	Excess/es:	R	R	R

2.	Do you require cover in respect of liability incurred but not discovered prior to the effecting of this insurance at a single premium to be negotiated?

DECLARATION

We declare that the statements and particulars in this Proposal Form are true to the best of our knowledge and belief and that we have not misstated, suppressed or omitted any material facts.

We agree that this Proposal Form together with any other information supplied by us shall form the basis of any contract of Insurance effected thereon and shall be incorporated therein.

We undertake to inform Insurers of any material alteration of these facts whether occurring before or after completion of the contract of Insurance.

Signing this Proposal Form does not bind the Proposer to complete this Insurance.

We acknowledge that if this proposal is accepted, the contract of insurance will be subject to the terms and conditions as set out in the policy wording.

DATED THIS _____ DAY OF _____ 20 _____

FOR AND ON BEHALF OF: _____

SIGNED BY:

_____ _____

PARTNER/ DIRECTOR/ MEMBER PARTNER/ DIRECTOR/ MEMBER

PLEASE NOTE: **This Proposal Form should be completed by YOU and signed by YOU. If the Proposal Form has been completed by your BROKER, review the Proposal Form before signing it. DO NOT sign a BLANK Proposal Form.**