MEDICAL INDEMNITY PROPOSAL FORM

Please complete this application form in block capitals, in black ink and return it to us by email to info@ethiqal.co.za.

* Kindly note that failure to disclose full and accurate details of any fact or circumstance that is relevant or may be considered relevant to the insurer's decision to extend cover to you, may result in the rejection of any claim or the cancellation of this insurance contract.

SECTION A: Personal Details

First name: _____

Surname: _____

Maiden/previous name: _____

Title: _____ Male: ☐ Female: ☐

Date of birth: _____

ID number: _____

Mobile number: _____

Work phone: _____

Emergency (after hours): _____

Facsimile: _____

Email address: _____

Website: _____

Nationality: _____

Country of permanent residence: _____

Address for correspondence: _____

_____

_____

_____ Postal code: _____

Address of principal office (if different from address above):

_____

_____

_____ Postal code: _____

Qualifications: _____

_____

_____

Date of primary qualification: _____

SECTION B: Practice Details

How long have you been practicing? _____

Statutory council number eg. HPCSA: _____

Are you registered as a specialist with the HPCSA or other registration authority in South Africa? Yes: ☐ No: ☐

If yes, please indicate your speciality and all applicable sub-specialities. Speciality: _____

Sub-specialities: _____

VAT Number (if applicable): _____

Do you treat patients who are citizens of other countries who have travelled specifically to receive treatment from you?

Yes: ☐ No: ☐

If yes, please provide details on the type of care and the number of patients treated in the past 12 months: _____

_____

Has your license ever been withdrawn? Yes: ☐ No: ☐

If yes, please provide details: _____

_____

Are you a member of any association or professional body, or registered with any self-regulating organization? Yes: ☐ No: ☐

If so, please provide details of that body and your registration number: _____

Has your membership or registration with such organisation ever been declined, withdrawn, suspended, or had conditions imposed? Yes: ☐ No: ☐

If yes, please provide details on a separate page

CONSTANTIA Insurance Company

SECTION C: Professional Credentials

Please list all your medical qualifications and the month/year in which they were awarded:

Qualification:	University:	Date Awarded:

What is your practice status in the current year?

- ☐ Academic
- ☐ Ships Doctor
- ☐ Solus
- ☐ Locum
- ☐ Associate
- ☐ Occupational med
- ☐ Partner
- ☐ Salaried
- ☐ NGO
- ☐ Supernumerary (PPP)
- ☐ Other

How is your time spent in your professional capacity?

☐ State hospital only ☐ Private practice ☐ Mix 75% State / 25% Private sessions ☐ Mix 25% State / 75% Private sessions

How many hours a week do you spend in private practice? ☐ How many private patients do you consult / week? ☐

How many hours per week do you spend:

Providing services in a private trauma / casualty unit: ☐
Performing locum work: ☐
Doing medico-legal consulting: ☐
Doing alcohol and drug rehabilitation: ☐
Repatriating patients: ☐
Conducting / participating in clinical trials: ☐

SECTION D: Specific Risk Elements

* If space provided is insufficient kindly submit answers on separate annexed page.

Do you, the insured, have any medical malpractice or professional indemnity? Yes: ☐ No: ☐

Name of Insurer:_____ Renewal Date:_____ Limit Of Indemnity: R_____

Have you had any break in clinical practice over the past 2 years? Yes: ☐ No: ☐

Has your professional status changed in the last 12 months? Yes: ☐ No: ☐

Has your professional role / job changed in the last 12 months? Yes: ☐ No: ☐

Has any Indemnity provider, in respect of the risks to which this application relates, ever:

a) declined an application, refused renewal or withdrawn cover? If so, please state the reason and provide relevant correspondence. Yes: ☐ No: ☐

b) required an increased premium or imposed special conditions? Yes: ☐ No: ☐

c) declined an indemnity / insurance claim by the Insured or reduced its liability to pay an insurance claim in full (other than by application of an excess)? Yes: ☐ No: ☐

Has any claim been made against you in respect of the risks to which this application relates? Yes: ☐ No: ☐

Have you incurred any other loss or expense which might be within the scope of your professional practice? Yes: ☐ No: ☐

(**if yes, please state on a separate annexed page:** Cost (if any) of claim paid, date & brief details of each claim or loss, estimated outstanding loss, actions taken to prevent a recurrence of the situation that gave rise to the claim or loss.

Please provide details of the procedures in place in your practice for dealing with patient complaints: _____

SECTION D: Specific Risk Elements (continued)

* Please share with us the average **number of procedures** you perform each week in each of the categories below:

INVASIVE PROCEDURES:	No / week
Needle biopsy:	
Dry needling:	
Intra-articular injections:	
Endoscopy:	

ANAESTHESIA:	
Conscious sedation:	
Localised anaesthesia:	
General anaesthesia:	

IMAGING:	
Non Obstetric ultrasound:	
Obstetric ultrasound (after 12 weeks gestation):	
X-ray:	

PRIVATE DELIVERIES:	
Last year:	
Current year:	

PRIVATE OBSTETRIC SERVICES:

INCLUDING ULTRASOUND BEYOND ANTE-NATAL CARE AFTER 12 WEEKS GESTATION

% time providing these services per week:	
Average number of patients per week:	

PRIVATE AESTHETIC/COSMETIC PROCEDURES:	No / week
Botox:	
Chemical peels incl. superficial peels:	
Facial sclerotherapy:	
Hair transplants:	
Microdermabrasion:	
Non-permanent dermal fillers:	
Photo-rejuvenation (laser incl. IPL / other)	
Sclerotherapy:	
Surgical procedures (describe):	
Tattoo removal:	
Lipolytic liposuction:	

PRIVATE REFRACTILE LASER SURGERY:	
Last year:	
Current year:	

TERMINATION OF PREGNANCY:	
Last year:	
Current year:	

VASECTOMY:

Kindly provide details on all relevant certifications, qualifications achieved in performing the above procedures.

Do you currently perform services in Accident and Emergency units? Yes: ☐ No: ☐

Please state the number of hours services are performed in the Accident and Emergency units? _____

SECTION E: Details of complaints, adverse clinical events & areas of concern

* If space provided is insufficient kindly submit answers on separate annexed page.

Have you ever received a complaint arising out of your professional practice?	Yes: ☐	No: ☐
Have you ever been involved in any disciplinary inquiry by your employer, individual medical scheme, HPCSA or any other Statutory Regulatory Health Body?	Yes: ☐	No: ☐
Have you ever had private practice privileges refused / withdrawn / made conditional by any registration body, association, hospital and / or other health care provider?	Yes: ☐	No: ☐
Have you ever had conditions imposed on your practice, been suspended or removed from a medical register due to a complaint, inquiry or investigation?	Yes: ☐	No: ☐
Have you ever been declared an "impaired physician" by the HPCSA or Statutory Body?	Yes: ☐	No: ☐

Please share any other issues and / or concerns that you may reasonably consider to be important and that we should be aware of in recording your professional conduct.

Claim / Complaint / Incident			
Status			
Date the complaint / incident was made			
Date the complaint / incident was notified			
Insurer			
Total value claimed / paid (if settled)			
Description of claim / complaint / incident			
Sanctions imposed upon you by your Regulatory Body?			

SECTION F: Attestation

* Please attest to the following statements. We may require additional documentation based on your responses.

	Agree:	Disagree:
I am NOT aware of request for records from a patient, family member of a patient, or an attorney	☐	☐
I am NOT aware of a letter from an attorney regarding my treatment that I provided to a patient	☐	☐
I am NOT aware of a patient, family member of a patient, or a patient representative's dissatisfaction with the outcome of a procedure, treatment, diagnosis or fee	☐	☐
I am NOT aware of any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit	☐	☐
I am not aware of any complaint, investigation or disciplinary action taken against me with any regulatory body, hospital committee, peer review committee, the Health Professionals Council of South Africa, or any other government or regulatory entity during the 3 years prior to the proposed effective date of this policy	☐	☐
I have NEVER been charged or convicted of any criminal offence	☐	☐
I have NEVER had any hospital privileges restricted, suspended, whether voluntarily or involuntarily, and I am not currently under investigation with any hospital	☐	☐
I have NEVER practiced medicine without medical professional liability coverage in force	☐	☐
I have NEVER had medical professional liability insurance	☐	☐
My licence to practice medicine and licence to dispense drugs and medication has NEVER been revoked or limited	☐	☐
I do NOT perform major surgical procedures in an office-based setting (procedures performed under general, spinal, or caudal anaesthesia)	☐	☐
I do NOT perform any procedures that are outside the customary scope of practice for which I am applying for coverage	☐	☐
I do NOT perform any of the following aesthetic procedures: Botox Injection, Chemical Peel, Cosmetic Tattooing, Laser Hair Removal, Laser Wrinkle Removal, Microdermabrasion, Permanent Makeup Sclerotherapy Smart Lipo, Fillers, Lipolytic Liposuction	☐	☐
(if you disagree with any of the above, please provide documentation of formal training for each specific procedure for which you are applying coverage)		
If any information supplied on this application changes between the application date and the effective date of insurance, I will immediately notify Constantia Insurance Company Limited (CICL) of such changes and CICL may withdraw or modify any outstanding quotations and / or authorisation or agreement to bind the insurance. I understand that my failure to notify CICL of any changes may be grounds for cancellation of the policy	☐	☐

Attestation additional information:

SECTION G: Declaration

I, the undersigned duly authorised, declare that:

(i) I am authorised to sign this application form;

(ii) All of the above statements are correct, true and complete;

(iii) No information material to this application form has been withheld;

(iv) I have read the important facts which you have put before me;

(v) I understand the advice given in relation to the duty of disclosure;

(vi) I have made all necessary enquiries in order to comply with the duty of disclosure;

(vii) I understand that no insurance is in force until such time as the Insurer has confirmed acceptance of the proposed insurance;

(viii) I undertake to inform the Insurer of any material alteration to these facts occurring before completion of the contract of insurance;

(ix) I acknowledge that the Insurer relies on the information and representations supplied by me in this application form and otherwise in relation to this insurance;

(x) except where indicated to the contrary, I understand that any statement made in this application form will be treated by the Insurer as a statement made by all persons to be insured;

(xi) I agree that this application form, together with any information supplied by me shall form the basis of any contract of insurance between myself and EthiQal, a division of Constantia Insurance Company Limited (CICL).

I provide authorisation to EthiQal to share the following information:

- ☐ The status of my application
- ☐ My claims history
- ☐ Quotations
- ☐ All details disclosed on my application form

with _____(Company)

Proposer: _____ Date: _____

Please note that only FSB registered consultants/ brokers/ advisors may provide any advice in terms of the EthiQal product. For any advice, please contact EthiQal directly.

INTERMEDIARY DETAILS

Broker:	
Broker FSP No:	
Consultant's Name:	
Telephone No:	
Email address:	

We recommend that you keep a record of all information supplied to CICL for the purpose of entering into this Policy.