Medical indemnity proposal form for doctors registered as specialists

MEDICAL INDEMNITY PROPOSAL FORM FOR DOCTORS REGISTERED AS SPECIALISTS

Thank you for your interest in EthiQal and for taking the time to share your practice details with us.
We look forward to being of service to you.

Please complete this application form and return it to us by email to info@ethiqal.co.za

IMPORTANT NOTICE

Answer all questions leaving no blank spaces.

It is our intention that any contract of insurance with you shall be based upon the answers and information provided in this application form and any other additional information provided by you. If a quotation is offered it will be our intention to offer coverage only in respect of the insured named in answer to SECTION A.

Please ensure that you inform us promptly if your personal circumstances and/or scope of practice change and/or if new medico-legal incidents occur subsequent to completion and submission of this form.

SECTION A: THE INSURED

A1. Personal Details
Personal information of the insured

First Name

Surname

Gender

☐ Male ☐ Female

ID Number

Mobile Number

Work Phone Number

Physical Address

Email Address

Post Code

A2. Professional Details

Professional qualifications and registration

HPCSA Number

HPCSA - registered field of practice / specialty / sub - specialty

Qualification

Type of Qualification	Name of University	Year of Joining

Are you a member of any Professional Association or Society? ☐ Yes ☐ No

If so, please provide details of the body (ies)

Name of Association / Society	Year of Joining

Specialist training and affiliation

If registered as a specialist, please indicate dates and place of registrar training

University Attended	Year From - Until

Professional indemnity cover

Do you currently have professional indemnity cover? ☐ Yes ☐ No

If yes, please provide the following details:

Name of Insurer

Renewal date - *YY / MM / DD*

Type of insurance cover

☐ Claims-made — Protection is only offered for incidents reported to the insurer whilst premiums are being paid and is subject to dates of cover

☐ Occurrence-based — You are protected for claims that result from any incident that occurs whilst being a policyholder, irrespective of when the claim occurs and includes the time after a policy has been cancelled.

☐ Both

If claims-made, please indicate original date of claims-made cover

Current limit of indemnity

What type of quotation would you like? ☐ Claims-made ☐ Occurrence-based ☐ Both

A3. Professional History

Please supply as much information as possible

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

If yes, please specifiy ______________________________

____

Has it ever been suggested by your employer, peers and / or a third party that you be mentored and / or placed under supervision? ☐ Yes ☐ No

If yes, please specifiy ______________________________

____

Have you ever been the subject of an inquiry by your employer, a non-regulatory professional body and / or a third party like a hospital or medical scheme? (e.g. following a patient complaint) ☐ Yes ☐ No

If yes, please specifiy ______________________________

____

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

If yes, please specifiy ______________________________

____

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

1. Declined an application, refused renewal or withdrawn cover? ☐ Yes ☐ No

2. Required an increased premium or imposed special conditions, including participation in risk management /education programs? ☐ Yes ☐ No

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

If you have answered 'yes' to any of the above, please provide details:

____

____

____

Have you ever received an HPCSA complaint, letter of demand or summons, arising out of your professional practice? ☐ Yes ☐ No

If yes, please provide full and complete details as per Appendix 1 (Page 17 of this document)

Except for cases which you have listed on Appendix 1, in the past three years, have you had a patient threaten legal action against you in your professional capacity, received a request for records and / or received a patient complaint / enquiry via a lawyer? ☐ Yes ☐ No

If yes, please provide full and complete details as per Appendix 2 (Page 18 of this document)

If there are 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, please share these below:

____

____

____

SECTION B: PRACTICE DETAILS

Please provide us with your practice details for the **period of insurance for which you are applying**.
For example, if you are currently a full-time employee in State, but are applying for insurance to cover you in private practice, answer questions in relation to your anticipated private practice.

B1. General

Employment status

Please indicate what practice status will be applicable during the period of insurance:

Full-time State employee ☐

If applicable, please specify level of employment (e.g. Medical Officer) ________________

Part-time State employee ☐

Solus private practice ☐

Private practice partnership ☐

Locum ☐

Salaried employee, non-government ☐

If applicable, please specify employer ________________

Other ☐

If applicable, please specify ________________

Place of work

For State – related work: Please indicate name and location of hospital / clinic where employed

Name of Hospital / Clinic	Location of Hospital / Clinic

For private practice: Please indicate name of hospital(s) where patients are treated routinely, including hospital group and hospital location

Name of Hospital	Hospital Group	Hospital Location	% of patients

If you are in private practice, please state year during which you first entered private practice

Practice Management

Will other staff (i.e. doctors, allied healthcare professionals and/or non-clinical staff) provide clinical services for which you would be vicariously responsible (e.g. nurse providing primary care services, beautician providing laser therapy, doctor employed in your practice)?

☐ Yes ☐ No

If yes, please complete the following, indicating number of professionals and their associated indemnity cover

	Constantia	MPS	Other	No Indemnity Cover
Doctor (permanent)				
Allied Health Professional				
Other				

If you employ locums, do you ensure;

1. That they are registered with the HPCSA? ☐ Yes ☐ No

2. That they carry indemnity cover? ☐ Yes ☐ No

Do you have a contractual relationship (e.g. service level agreement) with another party that requires you to have indemnity cover? ☐ Yes ☐ No

If yes, please provide details

Can you confirm that all your patients sign consent for treatment? ☐ Yes ☐ No

Who in your practice takes informed consent from patients?

What is the current system you use for patient notes? ☐ Hard copy ☐ Electronic

How are these records secured? ☐ Hard copy ☐ Electronic

What are the procedures in place in your practice for dealing with patient complaints?

Practice Income

Government basic salary (if applicable) R

Gross annual fees collected in relation to private clinical professional services rendered.

Gross Income R

VAT Number (if applicable)

B2. Scope of Work

Will you consult international patients (excluding those who are resident in the SADC region) on a regular basis?

☐ Yes ☐ No

If yes, how many patients **per annum?**

List all mechanisms used, if any, to attract international patients:

Will you conduct/participate in clinical trials? ☐ Yes ☐ No

Will you regularly repatriate patients? ☐ Yes ☐ No

Will you perform conscious sedation in your rooms and / or theatre owned by you / your practice? ☐ Yes ☐ No

If yes, please specify for what type of procedures

Will you perform procedures that require general/spinal/caudal anesthesia or conscious sedation in your rooms and/or theatre owned by you/your practice? ☐ Yes ☐ No

If yes, please provide details

Do you have a field of special interest within your area of practice/specialty? ☐ Yes ☐ No

If yes, please provide details

Will you do procedures that are more commonly performed by other specialist types and/or provide care that may be deemed to be experimental (e.g. not generally performed by your colleagues for reasons of limited evidence)? ☐ Yes ☐ No

If yes, please provide details

On average, how many patients will you consult **per month?** ☐

Other than the clinical services described in your answers in sections A and B, are there any other professional activities like, for example, voluntary work or paid advisory services to companies, for which you may look to EthiQal for assistance should an adverse event arise from such activity? ☐ Yes ☐ No

If yes, please specify

Note: Move straight to Section C if none of the below specialty-specific questions apply to you.

B3. Speciality-specific Services

For anyone performing in-theatre surgical procedures

How many procedures do you perform on average **per annum** as **primary** surgeon? ☐

On average, in how many procedures **per annum** do you act as an **assistant** surgeon? ☐

Do you treat children (12 years of age or younger)? ☐ Yes ☐ No

If yes, what percentage of your patient base do they represent? ☐ %

Do you perform cosmetic procedures? ☐ Yes ☐ No

If yes, what percentage of your patient base do they represent? ☐ %

For neurosurgeons

Do you perform spinal procedures? ☐ Yes ☐ No

If yes, how many of the following do you perform **per annum** as **primary** surgeon?

- Radiofrequency ablation ☐
- Vertebroplasty/kyphoplasty ☐
- Artificial disc implant ☐
- Spinal fusions with instrumentation ☐

For orthopaedic surgeons

Do you perform spinal procedures? ☐ Yes ☐ No

If yes, how many of the following do you perform **per annum** as **primary** surgeon?

- Radiofrequency ablation ☐
- Vertebroplasty/kyphoplasty ☐
- Artificial disc implant ☐
- Spinal fusions with instrumentation ☐

Do you do knee and/or hip replacements? ☐ Yes ☐ No

If yes, how many of these procedures do you perform **per annum** as **primary** surgeon? ☐

Do you provide general trauma cover? ☐ Yes ☐ No

For general surgeons

Do you perform bariatric surgery? ☐ Yes ☐ No

If yes, how many of these procedures do you perform **per annum** as **primary** surgeon? ☐

Do you perform laparoscopic surgery? ☐ Yes ☐ No

If yes, how many of these procedures do you perform **per annum** as **primary** surgeon? ☐

- Any additional training obtained in this field (e.g. fellowship), please specify

For obstetricians and gynaecologists

Do you provide obstetric services (defined as care of pregnant women after 24 weeks gestation)? ☐ Yes ☐ No

If yes, please specify

- Number of deliveries **per annum** ☐
- Percentage of deliveries that are performed by Caesarian section ☐ %

Do you perform / report on detailed pregnancy scans, including nuchal translucency scans that are aimed at detecting foetal anomalies? ☐ Yes ☐ No

Do you perform endoscopic surgical procedures? ☐ Yes ☐ No

If yes, please specify

- How many of these procedures do you perform **per annum** as **primary** surgeon? ☐
- Any additional training obtained in this field (e.g. fellowship, Winners level of accreditation)

For urologists

Do you perform laparoscopic surgery? ☐ Yes ☐ No

If yes, how many of these procedures do you perform **per annum** as **primary** surgeon? ☐

- Any additional training obtained in this field (e.g. fellowship), please specify

For anaesthetists

Do you provide chronic pain management? ☐ Yes ☐ No

If yes, do you perform Radiofrequency Ablation? ☐ Yes ☐ No

If yes, average number of procedures **per annum** ☐

For ophthalmologists

Does your practice provide screening for/treatment of retinopathy of prematurity? ☐ Yes ☐ No

Do you perform Laser refractive surgery? ☐ Yes ☐ No

If yes, average number of procedures **per annum** ☐

For plastic and reconstructive surgeons

In terms of the number of patients you treat, what percentage of your patients are anticipated to have predominantly cosmetic as opposed to reconstructive procedures? ☐ %

For paediatricians

Do you treat infants in the first 28 days of life? ☐ Yes ☐ No

If yes, please specify

- Do you attend deliveries? ☐ Yes ☐ No
- Do you look after neonates in the ICU? ☐ Yes ☐ No
- Are there protocols in place in the neonatal ICU(s) in which you work? ☐ Yes ☐ No

For radiologists

Do you perform/report on detailed pregnancy scans, including nuchal translucency scans that are aimed at detecting foetal anomalies? ☐ Yes ☐ No

If yes, how many on average **per month**? ☐

Do you perform interventional procedures? ☐

If yes, please specify

SECTION C: ATTESTATION

Please attest to the following statements. If you DISAGREE with any of the statements, please provide additional and complete information.

I have never had my licence to practice medicine and / or licence to dispense medicines revoked or limited. ☐ Agree ☐ Disagree

I have never been charged or convicted of any criminal offence. ☐ Agree ☐ Disagree

I have never had any hospital privileges restricted, suspended, whether voluntarily or involuntarily, and I am not currently under investigation by any hospital. ☐ Agree ☐ Disagree

I do not perform any procedures that are outside the customary scope of practice for which I am applying for coverage. ☐ Agree ☐ Disagree

I have never been part of a forensic audit by a medical scheme and I have never had a payment by a medical scheme reversed for reasons of alleged over-billing / over-servicing. ☐ Agree ☐ Disagree

I have never been declared an ‘impaired physician’ by the HPCSA. ☐ Agree ☐ Disagree

If you require backdated cover, please also attest to the following:

I have notified my current/previous insurer(s) of all the following for the time period for which backdated cover is being requested.

Request for records (for reasons other than processing of RAF or COID applications) from a patient, family member/custodian of a patient, or an attorney. ☐ Agree ☐ Disagree

Letter from an attorney regarding diagnosis, treatment and / or advice that I provided to a patient. ☐ Agree ☐ Disagree

Threat of a legal, including HPCSA, claim against me in my professional capacity, even if such action is without merit.	☐ Agree	☐ Disagree
Any unexplained and / or unusual adverse clinical outcome.	☐ Agree	☐ Disagree
An awareness of a failing or short-coming of my work, or real doubt about my clinical performance or a party for whom I am responsible in the course of my professional activities, which could give rise to a third-party loss.	☐ Agree	☐ Disagree
HPCSA complaints, even if you deem these to be without merit.	☐ Agree	☐ Disagree

Please also provide a list of all notifications submitted to your previous insurer(s), in **Appendix 3** (Page 19).

SECTION D: DECLARATION

I, the undersigned, am duly authorised and declare that:

• I certify that the following contained in this application is true, correct and complete to the best of my knowledge, and that reasonable inquiry has been made to obtain the answers herein;

• I have disclosed all material facts to the underwriting of the risks to be insured and will continue to do so whilst my policy is in force;

• I understand that the information contained in this application for insurance, which insurers have relied upon, shall form part of the basis of the contract of insurance;

• I do and will always, and for the duration of my insurance, maintain my registration in good standing with all relevant regulatory and / or professional bodies;

• I understand that signing this application form does not bind myself to complete this insurance, nor does it bind the insurer to accept my application;

• I undertake to inform insurers of any material change to these facts, whether occurring before or after completion of the insurance contract and that insurers may withdraw or modify any outstanding quotations and / or authorisations or agreement to bind the insurance;

• I understand that any failure on my part to notify insurers of any material changes be grounds for cancellation of the insurance contract.

I hereby authorise and consent to EthiQal:

• Obtaining any documentation, information and data, including my claims history, relating to my insurance cover held by my previous and current indemnity provider(s), which includes my membership with the Medical Protection Society;

• Approaching any person, including the Health Professions Council of South Africa, and any other professional body, hospital (i.e. any private or state facility), medical scheme or insurer for any information concerning my practice, including practice statistics and details regarding my diagnosis and treatment of patients and any claims against me or any inquest, criminal proceedings or litigation in which I am or have been involved as party or witness;

• Obtaining any documentation, information and data, relating to my practice from various hospitals, including state facilities, as and when EthiQal may require from time to time;

• Processing all facts disclosed and obtained, for the purposes of assessing my risk profile and / or underwriting the risks and relating to performance of any policy rights and obligations and promoting good health care practices;

• Using my anonymised data for research and education.

I also provide authorisation for EthiQal to share the status of my application and quotation with

Proposer Signature

Date

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

Intermediary details

Broker	
Broker FSP No	
Consultants 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.

APPENDIX 1

CASE ONE	
Complaint type (e.g. HPCSA complaint; letter of demand; summons)	

Case Description____

Year of Incident		**Monetary amount claimed**	**R**

Outcome (e.g. no sanction imposed by regulatory body; monetary settlement paid; case ongoing)

CASE TWO	
Complaint type (e.g. HPCSA complaint; letter of demand; summons)	

Case Description____

Year of Incident		**Monetary amount claimed**	**R**

Outcome (e.g. no sanction imposed by regulatory body; monetary settlement paid; case ongoing)

CASE THREE	
Complaint type (e.g. HPCSA complaint; letter of demand; summons)	

Case Description____

Year of Incident		**Monetary amount claimed**	**R**

Outcome (e.g. no sanction imposed by regulatory body; monetary settlement paid; case ongoing)

APPENDIX 2

CASE ONE	
Complaint type (e.g. request for records; threatening letter)	

Case Description____

Year of Incident	

Outcome (e.g. complaint against other treating doctor; case ongoing)________________

CASE TWO	
Complaint type (e.g. request for records; threatening letter)	

Case Description____

Year of Incident	

Outcome (e.g. complaint against other treating doctor; case ongoing)________________

CASE THREE	
Complaint type (e.g. request for records; threatening letter)	

Case Description____

Year of Incident	

Outcome (e.g. complaint against other treating doctor; case ongoing)________________

APPENDIX 3

CASE ONE	

Notification type (e.g. HPCSA complaint; letter of demand; summons; unexplained or unusual outcome; known error)

Case Description____

Date notified		**Insurer notified**	

CASE TWO	

Notification type (e.g. HPCSA complaint; letter of demand; summons; unexplained or unusual outcome; known error)

Case Description____

Date notified		**Insurer notified**	

CASE THREE	

Notification type (e.g. HPCSA complaint; letter of demand; summons; unexplained or unusual outcome; known error)

Case Description____

Date notified		**Insurer notified**	