ETHIQAL

Medical Indemnity Proposal Form for General Practitioners, including Family Medicine Specialists

INTRODUCTION

Thank you for your interest in EthiQal and for taking the time to provide us with your practice details for the purposes of entering into a medical malpractice contract of insurance. Please answer all questions, unless stated as not required.

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 name as stated in the Personal Details section below. 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.

PERSONAL DETAILS

1. Title(s)			
2. First name(s)		3. Surname	
4. Gender		Male ☐	Female ☐
5. ID number			
6. Cell phone number		7. Office number	
8. Email address		9. Practice email address	
10. Practice address	Room no. and building		Street no. and name
Suburb		City	
Province		Postal code	

QUOTATION DETAILS

1. What type of quotation(s) would you like?	Claims-made ☐	Comprehensive ☐	Both ☐

Your financial advisor will inform you about our Claims-made Policy and Comprehensive Policy.

2. If you are currently on claims-made cover, do you require retroactive cover?	Yes ☐	No ☐	From

Retroactive cover – This ensures that you have cover for claims which you are currently unaware of, that might arise from healthcare incidents prior to taking out the new policy, but not before the retroactive date.

Please provide a copy of your current professional indemnity schedule if applying for retro cover.

3. Please indicate your preference of premium payment:

Monthly ☐	Once-off as a single annual instalment (5% premium deduction applies to this option) ☐

PROFESSIONAL DETAILS

Registration, qualification and training

1. HPCSA registration number			
2. What is your HPCSA Speciality?			
3. Practice number(s)	1.	2.	3.

4. Qualification details

Degree obtained	Year achieved	Name of university

5. If you have completed registrar training, where did you train?

Name of university	Name of hospital	Year from	Year to

6. Additional training, certification and affiliation

- Please indicate any additional training received, including fellowships.

Institution	Year from	Year to	Name of programme/course	Certification received (e.g. ATLS, Fellowship Certification)

- If you have advanced life support training and certification, what date is this renewable?

Professional association or society

1. Are you a member of any professional association or society?	Yes ☐	No ☐

If yes, please complete the following.

Professional association or society	Year from	Year to	Position (e.g. member, past president or incoming president, EXCO)

PREVIOUS PROFESSIONAL INDEMNITY (PI) COVER

1. Do you currently have or have you previously had professional indemnity cover?	Yes ☐	No ☐

If yes, please provide details of this cover in **chronological** order in the section below.

Name of insurer	Start date	End date	Type of cover - Claims-made (CM) or Occurence-based (OB)	If CM, please indicate original date of cover	Limit of insurance
					R
					R
					R

2. What is your current premium per annum excluding VAT for PI cover? **R**

PROFESSIONAL HISTORY

1. Have you ever received a regulatory complaint (e.g. HPCSA, OHSC), letter of demand or summons arising out of your professional practice?	Yes ☐	No ☐
If yes, please specify details in the template provided in Annexure A.		
2. Except for the cases that you have listed above, in the past 5 years, have you had a patient threaten legal action against you in your professional capacity, received a request for records, received a patient complaint/inquiry via a lawyer, been involved in an inquest or received a subpoena in a medical case?	Yes ☐	No ☐
If yes, please specify details in the template provided in Annexure B.		
3. Has your professional status or professional role/job changed in the past 12 months?	Yes ☐	No ☐
4. Have you had any break in clinical practice over the past 5 years?	Yes ☐	No ☐
5. Has it ever been suggested by your employer, peers and/or third party that you be mentored and/or placed under supervision?	Yes ☐	No ☐
6. 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 ☐
7. Have you ever had conditions imposed on your practice, been suspended or removed from the medical register due to a complaint, inquiry or investigation?	Yes ☐	No ☐

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

• Declined an application, refused renewal or withdrawn cover?	Yes ☐	No ☐
• Imposed an extraordinary increase in premiums and/or special conditions, including participation in risk management/educational programme?	Yes ☐	No ☐
• 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 ☐

9. If you have answered "Yes" to any of the questions 3-8 above, or 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 provide details in the space "Additional details" below. These should include interactions with foreign regulatory authorities and healthcare systems.

10. Additional details

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, only answer questions in relation to your anticipated full-time **private** practice.

Type of practice

Do you perform any work for the State? If yes, please complete the "State employment" section first. If no, complete the "Private practice" section only.	Yes ☐	No ☐

State employment

Please specify type of State employment:

• Permanent staff ☐	• Sessional doctor ☐

If applicable, please provide the following details:

Position held	Name of department	Name of hospital/clinic

Private Practice

1. Please specify type of private practice. Tick all boxes that are applicable.

• Solus private practice ☐	• Private practice partnership ☐	• Private group practice ☐
• Associate ☐	• Locum (clinical work) ☐	
• Salaried ☐ (if selected, please specify):	Employer:	Position held:
• Other		

2. Please indicate name of hospital(s) where you treat patients in a private capacity.

Name of hospital	Hospital group	% of your private patients admitted per annum

3. Year of first seeing private patients:

4. If you are entering private practice for the first time, are you:

• Setting up a new practice ☐	• Joining an established practice ☐	• Taking over an established practice ☐
• Locum and on-call work only ☐		

If entering private practice for the first time, please append hospital admission rights for the hospital(s) where you will be practicing.

Practice management

1. Will other staff in your practice (e.g. 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 specify details below.

Name	Practitioner type e.g. GP, specialist, nurse, physiotherapist	Are they registered with the relevant Health Professions Council? (Y/N)	Personal professional indemnity cover (Y/N)

2. Do you employ locums?	Yes ☐	No ☐

If yes, please specify details below:

• Do you ensure that they are registered with the HPCSA?	Yes ☐	No ☐
• Do you ensure that they carry indemnity cover?	Yes ☐	No ☐

Patient records

1. Do all your patients sign consent for consultations?	Yes ☐	No ☐
2. Do all your patients sign consent for surgical procedures, and/or in-theatre treatments?	Yes ☐	No ☐

If yes, where and how is the signature recorded? (e.g. paper hospital form, manual practice forms, electronic form)

3. Who takes informed consent from patients for procedures?

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

If electronic, please specify which system you use:

5. What are the procedures in place to secure these records?

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

7. Do you comply with HPCSA's guideline on keeping of patient records?	Yes ☐	No ☐	Unsure ☐

Practice income	
1. **Gross annual income** in relation to **government** clinical professional services rendered:	R
2. **Total annual billing** in relation to **private** clinical professional services rendered:	R
3. **Total annual earnings** received in terms of providing medico-legal services:	R
4. VAT number (if applicable).	

SCOPE OF WORK

International patients		
1. Do you regularly treat international patients who have travelled to receive treatment from you?	Yes ☐	No ☐
If yes, how many on average in the past 12 months?		

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

3. Will you regularly repatriate patients?	Yes ☐	No ☐

Scope of practice		
Where possible, please specify current and anticipated future figures		
1. On average, how many patients will you consult per **month**?	Past year	Coming year
2. Will you conduct/participate in clinical trials?	Yes ☐	No ☐

3. Please confirm the % breakdown of time spent on professional activities offered by you for which you require cover:

Activity	% time in past year	% time in coming year
Private		
General consultations		
Aesthetics		
Accident and emergency		
Minor procedures in rooms		
In-theatre procedures		
Obstetrics		
Telemedicine		
Government		

4. Do you perform general/spinal/caudal anaesthesia?	Yes ☐	No ☐

If yes, please complete the following:

- Please provide details of anaesthetic experience in the public sector.

Public sector position held	Year from	Year to

• Please specify from which year you have been performing anaesthetics in the private sector.				
• Do you perform general anaesthesia on children under age 1 year or on pregnant women?		Yes ☐	No ☐	
• Average number of patients treated per **annum**	Past year		Coming year	
5. Do you perform **conscious sedation** or **any procedure under conscious sedation** in a facility other than an emergency unit or hospital theatre?		Yes ☐	No ☐	

If yes, please complete Annexure C.

6. Do you provide emergency services in a private casualty/trauma unit?	Yes ☐	No ☐

If yes, please complete the following:

• Please provide details of casualty/trauma unit experience in the public sector.

Public sector position held	Year from	Year to

• Please specify from which year you have been performing emergency services in the private sector:	
• Average number of hours per **week** that emergency services are provided:	

7. Do you perform aesthetic/cosmetic procedures e.g. Botox®, non-permanent fillers, chemical facial peels, collagen injections, hair transplants without flap surgery, laser therapy, thread lifting, liposuction or sclerotherapy?	Yes ☐	No ☐

If yes, please complete the following:

Procedures	% of time spent	No. of years performed	Training and certification incl. year obtained

8. Do you perform circumcisions and/or terminations of pregnancy?	Yes ☐	No ☐

If yes, please specify.

9. Do you perform surgical procedures typically performed within an operating theatre as the primary surgeon e.g. tonsillectomy, appendectomy, vasectomy?	Yes ☐	No ☐

If yes, please specify the types of procedures and approximate number per **annum**.

Procedure	Past year	Coming year

10. Do you provide surgical assistance?	Yes ☐	No ☐

If yes, please complete the following:

• Do you assist with obstetric, neurosurgical and spinal or bariatric cases?	Yes ☐	No ☐

If yes, please specify:

• How many surgeons do you assist regularly?	Past year		Coming year
• Is your assistance limited to holding instruments in theatre to support the primary surgeon?	Yes ☐	No ☐	

If no, please provide **as much detail** as possible (e.g. position the patient and start surgery to prepare operative field, perform surgical closure, provide post-operative care, teach/supervise a particular skill):

11. Do you perform planned deliveries?	Yes ☐	No ☐

If yes, please complete the questions listed in Annexure D.

12. Do you perform basic pregnancy scans?	Yes ☐	No ☐

If yes, please complete the following:

• Do you have an informed consent form that specifies intentions and limitations of the scan?	Yes ☐	No ☐

- Please provide details of experience and training.

13. Do you offer fetal abnormality screening to patients?	Yes ☐	No ☐

If yes, please provide details:

14. Other than clinical services described in your answers, 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 provide details:

15. Do you practice telehealth other than as a consulting practitioner to the primary caregiver? Telehealth includes the remote diagnosis and treatment of new patients and new conditions of existing patients by means of telecommunications technology.	Yes ☐	No ☐

If yes, please provide details:

16. Will you do procedures 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:

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

If yes, please provide details:

ATTESTATION

Please attest to the following statements. If you **DISAGREE** with any of the statements, please provide additional and complete information in the space provided at the end of the section.

1. I have never had my license to practice medicine and/or license to dispense medicines revoked or limited.	Agree ☐	Disagree ☐
2. I have never been charged or convicted of any criminal offence.	Agree ☐	Disagree ☐
3. 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 ☐
4. I do not perform any procedures that are outside the customary scope of practice for which I am applying for coverage.	Agree ☐	Disagree ☐
5. 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 ☐
6. I have never been declared an "impaired physician" by the HPCSA.	Agree ☐	Disagree ☐

Additional Attestation Information

If retroactive cover is required, please also attest to the following and provide additional and complete information at the end of the section.

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

• Requests 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, treatments 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 ☐

Additional Attestation Information

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 claims history, relating to my insurance cover held by my previous and current indemnity provider(s), which includes my membership with overseas regulated societies (e.g. Medical Protection Society), if applicable;
- 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 the FSCA 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 number	
Consultants name		Telephone number	
Email address			

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

ANNEXURES

Annexure A: Previous case history – regulatory complaint (e.g. HPCSA, OHSC), letter of demand or summons.

Insurer	Case number	Complaint type	Year of incident	Monetary amount claimed	Case description	If case is closed, what was the outcome (e.g. sanction type imposed, monetary settlement paid)?
				R		
				R		
				R		
				R		

Annexure B: Previous case history – notification, advice/assistance, request for records, written complaint, mediation, inquiry, inquest, subpoena (note: where a request for records is known to be against a third party, this should be noted).

Insurer	Case number	Complaint type	Year of incident	Case description

Annexure C: Conscious sedation

1. Do you perform any **procedures under conscious sedation** in an **office-based setting**, i.e. not in an emergency unit or hospital theatre?	Yes ☐	No ☐

If yes, please specify:

- What type of procedures are performed under conscious sedation?

• Who administers conscious sedation?	You as the practitioner ☐	Other practitioner ☐

If other, please specify (e.g. anaesthetist, GP):

2. Do you perform **conscious sedation** other than in an emergency unit or hospital theatre?	Yes ☐	No ☐

If yes, please complete the following:

- Do you perform conscious sedation in your rooms or another practitioner's rooms?

- If you administer the conscious sedation drugs and also perform the associated procedure, what type of practitioner assists you, if any (e.g. nurse)?

- Unless specified in point 1 above, for which procedures do you perform conscious sedation?

- What drug regimen(s) do you use?

• Do you have emergency protocols in place?	Yes ☐	No ☐
• Do you keep a logbook of all cases?	Yes ☐	No ☐
• Are the facilities in which you carry out conscious sedation accredited by SOSPOSA or COHSASA?	Yes ☐	No ☐
• Are these facilities equipped with the necessary equipment and drugs required in an emergency?	Yes ☐	No ☐
• Is resuscitation equipment checked and maintained regularly?	Yes ☐	No ☐
• Is the facility where sedation takes place within a hospital building with an ICU?	Yes ☐	No ☐

If no, in what proximity is the closest ICU?

• Do you perform conscious sedation on children under age 1 year or on pregnant women?	Yes ☐	No ☐
• Do you have informed consent forms specific to conscious sedation?	Yes ☐	No ☐
• Do you keep sedation monitoring charts?	Yes ☐	No ☐
• Do you provide patients with post-discharge patient information leaflets?	Yes ☐	No ☐

• Average number of patients sedated per **annum**	Past year:	Coming year:

If available, please submit copies of informed consent forms and other documentation such as sedation monitoring chart and post-discharge patient information leaflet that you may be using where you perform conscious sedation.

Annexure D: Planned Deliveries

If you have answered 'Yes' to question 11 on page 8 and you perform planned deliveries, please complete these questions.

- Please provide details of obstetric experience in the public sector.

Public sector position held	Year from	Year to

- Please specify from which year you have been performing deliveries in the private sector.

- Average number of deliveries per annum — Past year | Coming year

- Percentage of deliveries by elective Caesarian Section — %

- Are all patients assessed by a specialist O&G during their pregnancy? — Yes ☐ No ☐

- If yes, at what stage of pregnancy do you refer your patients?

- If no, when do you refer patients?

- Who performs the delivery if you are unavailable, i.e. who provides emergency back-up cover?

- What protocols do you follow for fetal monitoring during active labour?

- What protocols do you follow for the use of oxytocic drugs?