Camargue

MISCELLANEOUS
HEALTHCARE

MEDICAL MALPRACTICE

IMPORTANT NOTICE

- Answer all questions leaving no blank spaces
- If you have sufficient space to complete any of your answers, continue on your headed paper
- It is in the intention of Underwriters that any Contract of Insurance with the Proposer shall be based upon the answers and information provided in this Proposal Form and any other additional 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.
- Completion of this form does not bind the Propose or Insurer to complete the insurance transaction.

1 | GENERAL INFORMATION

Details of entities to be insured (the "Proposer")

Proposer's Name:

ID number (if Sole Trader):

Trading Name (if different from above):

Physical Address:

Postal Code:

Practice/Trading Address/es if different from the above:

Company Reg No: VAT No: VAT No:

Date Company Established / Services Commenced: / /
As currently constituted

Date Company Established / Services Commenced: / /
As initially established:

Contact Name: Contact number:

Email: Website:

Company Legal Constitution: Partnership / Private Company / Public Company / Close Corporation / Non-profit Organisation / Government / Sole Proprietor

AUTHORISED FINANCIAL SERVICES PROVIDER, LICENCE NUMBER: 6344. APPROVED LLOYD'S COVERHOLDER PIN: 107824DRW
Camargue Underwriting Managers (Pty) Ltd. Co. Reg. No. 2000/028098/07.
33 Glenhove Road, Melrose Estate, 2196. Postnet Suite 250, Private Bag X4, Bedfordview 2008
Telephone: 011 778 9140, Facsimile: 011 778 9199, E-mail: camargue@camargueum.co.za, Website: www.camargueum.co.za

2| Insurance History

1. Are you in the present or have you in the past been Insured, for the type of Insurance now being proposed? YES NO

If Yes, please state: Insurer: .....

Limit of Indemnity:	R
Excess:	R
Premium:	R
Date of expiry of coverage:	
Retroactive Date:	

2. For the type of Insurance now being proposed, has any Insurer ever:

a. Required an increased premium or imposed special terms? YES NO

b. Refused to accept or renew any insurance for the body corporate YES NO

c. Cancelled the insurance? YES NO

If any answer is Yes to any of the above 3 questions, please provide full details

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3 | Required Cover

1. State the LIMIT OF INDEMNITY and EXCESS required:

Limit:	R	R	R
Excess:	R	R	R

4 | Previous Losses/ Existing Circumstances

1. Please provide the following details in relation to the Proposer's business:

a. Any claim, circumstance, complaint or proceedings brought or threatened against the Proposer, or any incident which could lead to such a claim, circumstance, complaint or proceedings (this includes written or verbal complaints or expressions of dissatisfaction against the Proposer or connected with the applicant)? YES NO

b. Any investigation or adverse finding by any professional body, tribunal, regulatory or registration body? YES NO

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c.	Any disciplinary action?	YES	NO
d.	Any conditions imposed on, suspension of, or revocation of the Proposer's licence or registration?	YES	NO
e.	Any criminal offence or formal police caution?	YES	NO
d.	Any conditions imposed on, suspension of, or revocation of the Proposer's licence or registration?	YES	NO
f.	Commencement of any regulatory body or medical defence organisation's 'adverse member procedure'?	YES	NO
g.	Declinature, termination, non-renewal or special conditions imposed by previous or current insurers?	YES	NO

2. If you have answered yes to any part of question 1 above, please provide details below:

.....

5 | Activities of Proposer

1. Please state the discipline(s) in which the Proposer is engaged:

.....

.....

.....

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

6 | Professional Services

1. Please give a full description of the business activities for which insurance is required:

.....

2. During the last 6 years, please provide details of any changes to the applicant's name(s), or any amalgamations or acquisitions which have taken place, or any changes to the partners, directors, or sole practitioners (i.e. departed, retired or deceased):

.....

3. During the last 6 years, please provide details of any changes to the applicant's clinical services:

.....

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4. Where does the applicant provide services to their client? (Please tick all appropriate boxes)

a) Trading address(es)/applicant's premises:		
b) Third party hospital/clinic:		
c) Prison/immigration centre:		
d) Medical teaching facility:		
e) Mobile facility:		
f) Long term care facility:		
g) Patient's home:		
h) School:		
i) Laboratory:		
j) Other (please specify):		

5. Is there any work undertaken for the Department of Health where liability is covered by government indemnity or equivalent scheme?

.....

6. If yes, please state or estimate the income generated for this work in the current financial year.

.....

7. Are there any major changes to the business planned in the forthcoming year? (If yes, please provide full details):

.....

8. Does the applicant sell or distribute any medical/pharmaceutical products and /or medical devices? (Not including those used on or by patients in the course of their treatment by the applicant)

.....

9. Does the applicant manufacture, alter, re-label, mix or blend products/devices in any way?

.....

10. If Yes to question 8. or 9. above, what was the gross income generated from these activities?

COUNTY OF SALE	CURRENCY	LAST FINANCIAL YEAR (ESTIMATE)	CURRENT FINANCIAL YEAR	PRINCIPAL ACTIVITIES

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11. Excluding work which is undertaken for the Department of Health and insured elsewhere, please complete each of the following fields applicable to the applicant's business:

CATEGORY	INFORMATION REQUIREMENT	LAST YEAR (ACTUAL)	NEXT YEAR (ESTIMATE)
Antenatal Clinic	# Visits		
Complimentary Therapy	# Visits		
Counselling	# Visits		
Cancer Treatment	# Visits		
Dentistry	# Visits		
Dermatology (cosmetic)	# Visits		
Dermatology (non-cosmetic)	# Visits		
Dialysis services	# Visits		
Domiciliary Care / Home Health Services	# Gross Receipts		
Drug /Alcohol Rehab (residential)	# Occupied Beds		
Elderly Care (Inpatient)	# Occupied Beds		
Gynaecology (non-surgical)	# Visits		
Health & Fitness Centre	# Visits		
Hyperbaric Oxygen Therapy	# Visits		
Imaging (Diagnostics)	Gross Receipts		
Imaging (Therapeutic)	Gross Receipts		
Learning Disabilities	# Visits		
Medical Repatriation	# Moves		
Medical Staffing Agency (Home Health / Nursing only)	# Gross Receipts		
Medical Staffing Agency (All other)	# Gross Receipts		
Nutrition / Dietetics	# Visits		
Occupational Health / Physiotherapy	# Visits		
Opticians / Optometry	# Gross Receipts		
Ophthalmology (non-surgical)	# Visits		
Paediatrics (non-surgical)	# Visits		
Palliative/Hospice Care	# Occupied Beds		
Paramedic / Ambulance Services (emergency transport)	# Moves		
Paramedic / Ambulance Services (routine/planned transport)	# Moves		
Pathology / Laboratory Services	# Gross Receipts		

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CATEGORY	INFORMATION REQUIREMENT	LAST YEAR (ACTUAL)	NEXT YEAR (ESTIMATE)
Pharmacy (prescription medication)	# Gross Receipts		
Pharmacy (OTC/Retail)	# Gross Receipts		
Primary Care: GP Led (for registered patients)	# Visits		
Primary Care: Minor Injuries / Walk-in Centre	# Visits		
Primary Care: Urgent (in-hours)	# Visits		
Primary Care: Urgent (out of hours)	# Visits		
Primary Care: GP Home Health Visiting (In-Hours)	# Visits		
Primary Care: Preventative/ Screening/Monitoring	# Visits		
Primary Care: Prison/Immigration Healthcare	# Visits		
Psychiatric/Counselling (outpatient)	# Visits		
Sports Medicine / Injury (non-surgical)	# Visits		
Surgery: Elective Cosmetic	# Procedures		
Surgery: Ophthalmic – Laser	# Procedures		
Surgery: Ophthalmic – Non-laser	# Procedures		
Surgery: Inpatient	# Procedures		
Surgery: Outpatient	# Procedures		
Termination of Pregnancy	# Terminations		
Other (Please Specify)	# Visits		
Other (Please Specify)	# Visits		

12. Does the applicant provide any inpatient facilities?

.....

13. If Yes, please provide details below:

DESCRIPTION OF SPECIALTY / SERVICE / CATEGORY	#LICENCED BEDS	#OCCUPIED BEDS

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14. What % (if any) of the applicant's patients outside the SADC region?

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15. What % (if any) of the applicant's patients are classed paediatric?

.....

16. Does the applicant provide Obstetric or Midwifery services?

.....

17. Does the applicant provide assisted conception services?

.....

18. Does the applicant operate, own or maintain any blood/sperm/egg/tissue banks?

.....

19. If yes to question 16, 17, & 18 above, please provide details.

.....

7 | Financial Information

1. **When was your immediate past financial year end:** .....

2. **Please state the total gross revenue generated from the applicant's business (a copy of the latest financial statements may be required):** .....

NAME OF SUBSIDIARY	LAST FINANCIAL YEAR (ACTUAL)	CURRENT FINANCIAL YEAR ESTIMATE	FORTHCOMING FINANCIAL YEAR ESTIMATE
Gross Revenue from Fees:	R	R	R
Gross Revenue from any other source (provide brief details on a separate page):	R	R	R
Total Revenue:	R	R	R

8 | Staff Complement

1. **Please list the Full Time Equivalent (being 40 hours per week) of the personnel working for, or on behalf of the applicant WHO REQUIRE COVERAGE UNDER THIS INSURANCE POLICY**

Registered Medical Practitioners (any HPCSA or equivalent Regulated Individuals):

SPECIALTY (EG. GP, RADIOLOGIST ETC.)	TOTAL HEADCOUNT	FULL TIME EQUIVALENT (EMPLOYED)	FULL TIME EQUIVALENT (SELF EMPLOYED)	FULL TIME EQUIVALENT (LOCUM / BANK)

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Allied Health Practitioners (any AHPCSA / HPCSA or equivalent Regulated Individuals):

SPECIALTY (EG. RADIOGRAPHER, OPTOMETRIST ETC.)	TOTAL HEADCOUNT	FULL TIME EQUIVALENT (EMPLOYED)	FULL TIME EQUIVALENT (SELF EMPLOYED)	FULL TIME EQUIVALENT (LOCUM / BANK)

Nurses (any SANC or equivalent Regulated Individuals)

CATEGORY	TOTAL HEADCOUNT	FULL TIME EQUIVALENT (EMPLOYED)	FULL TIME EQUIVALENT (SELF EMPLOYED)	FULL TIME EQUIVALENT (LOCUM / BANK)
Dental Nurse:				
Midwife:				
Registered Nurse / Practice Nurse:				
Nurse Anesthetist:				
Nurse Practitioner (prescriptive, diagnostic authority):				
Nurse Practitioner (no prescriptive, diagnostic authority):				
Surgical Nurse:				
Other (please specify):				

Other Clinical Staff:

CATEGORY (EG. HCA, PHLEBOTOMIST ETC.)	TOTAL HEADCOUNT	FULL TIME EQUIVALENT (EMPLOYED)	FULL TIME EQUIVALENT (SELF EMPLOYED)	FULL TIME EQUIVALENT (LOCUM / BANK)

Non-Clinical Staff:

CATEGORY (EG. DRIVER, CLERICAL ETC.)	TOTAL HEADCOUNT	FULL TIME EQUIVALENT (EMPLOYED)	FULL TIME EQUIVALENT (SELF EMPLOYED)	FULL TIME EQUIVALENT (LOCUM / BANK)

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9 | Risk Management

1. Is the applicant registered with the HPCSA or equivalent?	YES	NO
2. If no to Question 1, is the applicant accredited, certified, licenced or registered with the appropriate regulatory authority? (please provide details below):		
3. When was the applicant last audited/inspected by the HPCSA/ Department of Health or other relevant regulatory authority? (please attach the latest report and provide any relevant details):		
4. Does the applicant record that all practitioners hold a valid licence to practice in their specialisations issued by the relevant lawfully established and recognised licencing authority in the appropriate territory? (eg, HPCSA etc.)	YES	NO
5. Does the applicant ensure and record that all employed and/or engaged medical and/ or dental practitioners are:		
a) Members of a medical or dental defence organisation and are fully indemnified by that organisation for the professional services undertaken by them on the applicant's behalf?	YES	NO
OR		
b) Fully insured for their own malpractice and any acts errors or omissions with a limit of liability of no less than the limit being requested in this application?	YES	NO
6. Does the applicant require all other self-employed individuals who work or provide services from the applicant's premises or who may expose the applicant to potential claims to carry their own insurance cover?	YES	NO
7. In respect of all personnel, does the application provide an induction programme and employee handbook in every case?	YES	NO
8. Does the applicant have formal procedures for ensuring that all personnel are provided with:		
a) Formal training	YES	NO
b) Supervision where necessary	YES	NO
c) Continuing education for permanent members of staff	YES	NO
d) Appraisal / assessment for permanent members of staff	YES	NO
e) A confidentiality clause includes in their contract / terms of service	YES	NO

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9. Does the applicant adopt the following quality controls and risk management procedures:

a)	Are patients provided with written material routinely as part of the consent procedures?	YES	NO
b)	Are patients consented by the practitioner who will be undertaking the procedure in every case?	YES	NO
c)	Are there protocols in place for the management of standard, frequently encountered conditions?	YES	NO
d)	Is there a system of ongoing audit to ensure compliance with protocols?	YES	NO
e)	Is there a formal complaints procedure?	YES	NO
f)	Is there a system for the reporting and investigation of adverse / significant events?	YES	NO
g)	Is there a health and safety policy?	YES	NO
h)	Is there a periodical Health & Safety training for all personnel (eg. manual handling)?	YES	NO
i)	Is there a protocol to ensure that good quality, contemporaneous medical records are made after all clinical contacts with patients (including telephone contacts)?	YES	NO
j)	Has the applicant had a risk assessment carried out by an independent organisation within the last 3 years?	YES	NO
k)	Are there procedures in place for the checking and maintenance of clinical equipment for devices owned by the applicant?	YES	NO
l)	Are leased clinical equipment or devices regularly checked and maintained by the supplier?	YES	NO
m)	Are there formal arrangements in place for communicating with a referred patient's GP for each assessment of their treatment?	YES	NO

10. Does the applicant provide facilities for the sterilization of instruments in accordance with the current guidelines? YES NO

11. Does the applicant have a protocol for needle stick injuries? YES NO

12. Does the applicant maintain, and continue to maintain accurate and descriptive records of all medical services provided for a specified period of time as determined by the Department of Health, HCPSA or equivalent guidelines? YES NO

13. If you have answered no to any question in SECTION 9, please provide details:

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10 | Additional Information

1. Is there any further information that should be made known to the Underwriters in order that they may from a proposer estimate of the risk? YES NO

If yes, please attach relevant brochures or publications, copies of contract conditions or advise on a separate page.

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DECLARATION

Signing this proposal form binds neither the proposer to complete this insurance, nor does it bind the insurer to accept the proposal. It is agreed that all written statements and attachments furnished to the insurer in conjunction with this proposal are hereby incorporated by reference into this proposal and made part thereof. It is understood and agreed that the insurer has relied upon this proposal and attachments, which shall be the basis of the insurance contract.

The undersigned is an authorised signatory of the Proposer and certifies that reasonable inquiry has been made to obtain the answers herein which are true, correct and complete to the best of his/her knowledge and belief. We undertake to inform the insurer of any material alteration to these facts, whether occuring before or after completion of the insurance contract

NAME **CAPACITY**

SIGNATURE OF THE PROPOSER **DATE** DD/MM/YYYY

BROKER DETAILS

Broker:

Contact Person: Tel:

Email: Fax number:

THE POWER OF KNOWLEDGE