Medical Malpractice Insurance Proposal Form

for General Practitioners, Dentists and Medical Practitioners other than Specialists

genoa Underwriting Managers

Authorised Financial Services Provider • FSP Number 38225

SAFIRE INSURANCE | SINCE 87

A licensed non-life insurer and authorised financial services provider [FSP no: 2092]

8.23

PART 1

General Section

Disclosure: medical practitioners / healthcare professionals

You must disclose to **Safire Insurance Company Limited** ("the Insurer") all information which is material to it in deciding whether to provide insurance cover to you, including any facts or conduct which might lead to a claim being made against you. Failure to do so could affect your cover. If you are in doubt, then rather disclose.

If you do not understand any part of this document, please contact your broker prior to signing it. You will be bound by the answers which are given, and by the information provided by you in this proposal form. It is in your interests to make sure that all information is correct and understood.

- This proposal form will be submitted on your behalf to the Insurer, and has been compiled in such a manner as to provide the Insurer with as much detail as possible to enable the Insurer to evaluate the risk. Completion of this form does not bind either you or the Insurer to complete the insurance transaction.
- To assist the Insurer in accurately assessing liability for rating purposes, you are requested to answer all the questions. Where a mark is required, please mark the appropriate box with an "X".
- Please answer ALL questions fully. Please note, replies such as "see your records", or "as previously advised" are not acceptable. If the space provided is insufficient, a separate sheet should be attached.

Privacy and Sharing of Information

In order to provide you with appropriate insurance, the Insurer/Underwriting Management Agency may at times have to process / share your personal information. The processing of the information will at all times be in the interests of the Policyholder and may include sharing of your personal information with insurers, re-insurers, underwriting managers, brokers, financial institutions, industry bodies, credit agencies and associated service providers (where applicable).

At all times the sharing of such information is limited to only that information which will allow the Insurer/Underwriting Management Agency to provide you with suitable insurance/replacement insurance, to allow the Insurer/Underwriting Management Agency to process claims on your behalf, to allow the Insurer/Underwriting Management Agency to conduct surveys and marketing initiatives, and to allow the Insurer/Underwriting Management Agency to correctly allocate premium payments.

We assure you that when the Insurer/Underwriting Management Agency share your personal information with selected service providers/third parties, for the specific purposes outlined herein, that we will ensure that the appropriate protections of your personal information are in place in accordance with our obligations under the POPIA. The Insurer/Underwriting Management Agency will take all reasonable steps to protect the personal information held in our possession against loss, unauthorised access, use, modification, disclosure, or misuse.

By signing this form, you:

- Acknowledge that the personal information you supplied is provided voluntarily and that you consent to the processing of such information for the purposes of providing you with insurance and for lawful business reasons/purposes. You further acknowledge that this consent can be revoked by you at any stage.
- Consent to your underwriting, claims or credit information being retained on any shared database of the Insurer/Underwriting Management Agency whether your policy is active or has been cancelled.

PART 2

Professional Indemnity and Medical Malpractice Section

SECTION A. Personal details of Proposer

1. Name and surname
2. ID number
3. Mobile number
4. Work Number
5. Country of permanent residence
6. Email address
7. Website

SECTION B. Practice Details

1. Practice address
2. Telephone number
3. VAT number (if applicable)
4. Practice Number (PCNS)
5. Regulatory registration number
6. How long have you been practicing?

SECTION C. Professional credentials

1. Please state your relevant qualifications and experience

Qualification(s)	Institution	Year achieved

2. Has your membership with any Professional body ever been refused/suspended/ withdrawn or had special conditions imposed? YES NO
   If YES, please provide details of the relevant circumstances.

3. Do you regularly 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.

SECTION D. Insured's professional activities

1. Please confirm the percentage breakdown of the professional activities offered by you and for which you require cover:

		%
		%
		%
		%
TOTAL	100%	

2. Should you perform any surgical procedures in an office-based setting (procedures performed under general, conscious sedation, spinal, or caudal anaesthesia) then please confirm what these procedures are below:

SECTION E. Practice Management

1. Is it mandatory that all your patients sign consent for:
   a. Consultations ☐ YES ☐ NO
   b. Surgical procedures and/or in theatre treatment ☐ YES ☐ NO
2. What is the current system you use to capture patient notes? ☐ Manual capture ☐ Electronic capture Other
3. How are your patient records secured? ☐ Hard copy ☐ Electronic format Other
4. How long do you retain patients' medical records?
5. Which of the following do you use for your internal risk management? ☐ Healthspace ☐ Medaware ☐ Medscape
   ☐ Up to Date ☐ Wordsure ☐ Other Specify ☐ None of the above

SECTION F. Insurance History

1. Are you currently or have been in the past insured for the type of insurance now being proposed ☐ YES ☐ NO
   If YES, then please confirm:

Current Insurers		Previous year's premium	
Limit of Indemnity		Renewal date	
Excess		Retroactive date*	

* only applicable if you were insured with a claims made policy in the past

2. Have you ever had a break in cover where you were not insured for a period of time? ☐ YES ☐ NO
3 Have you had any break in clinical practice over the past 5 years? ☐ YES ☐ NO
   If you answered YES to any of the above, then please give details.

SECTION G. Claims Experience

1. Has any formal written complaint been made against you with any regulatory body, including the HPCSA, in your capacity as a medical practitioner? ☐ YES ☐ NO
2. Has any disciplinary enquiry been initiated against you with any regulatory body, including the HPCSA, in your capacity as a medical practitioner? ☐ YES ☐ NO
3. Has any monetary claim been made against you arising out of your professional conduct as a medical practitioner? ☐ YES ☐ NO

If you answered YES to any of the questions above, please give details below (attach a back page if necessary):

Date of claim/ loss/Date of claim/ incident	Date the claim/ loss/complaint/ incident was made	Full details of each claim/loss/ complaint/ incident	Total amount claimed	Total amount paid

4. Are you aware of any circumstances which might give rise to a claim against you which has not already been initiated? ☐ YES ☐ NO

   If you answered YES, then please give details below.

SECTION H. Fee Income

1. Please indicate the Gross taxable turnover for the relevant periods shown below:

Annual Total	Annual Gross income for the previous financial year	Annual Gross income estimated the next financial year
Private practice		
Government practice		
Medico-legal Services		

2. Please indicate the % time spent in your Professional Capacity in: State Hospitals ____ % Private Practice ____ %
3. How many hours a week do you spend in: State Hospitals ____ hours Private Practice ____ hours
4. State the number of:
   a. Annual consultations: previous year ____ current year ____
   b. Annual procedures / surgical treatments performed: previous year ____ current year ____

PART 3

Specific Extensions and VAPS Section

SECTION I. Additional Extended Reporting Period (AERP)

1. Do you require an Additional Extended Reporting Period in excess of the 60 months (5 years) currently offered by the Policy? ☐ YES ☐ NO
2. If YES, please confirm whether you would like a quote for the Additional Extended Reporting Period extension? ☐ YES ☐ NO

SECTION J. Hospital at Home Services

1. Do you provide Hospital at Home Services? *(ask your broker for a definition)* ☐ YES ☐ NO
2. If YES, please list the institutions / medical schemes that you provide Hospital at Home Services for.

SECTION K. Medical Aid Scheme and/or Third Party Administrator Forensic Audit Opposition Costs

1. Do you require assistance with costs to challenge an audit by a third party payer and or a medical scheme? ☐ YES ☐ NO
2. If YES, please indicate which limit you require: ☐ R25,000 ☐ R50,000

Section L: Medico-legal Services

1. Do you provide Medico-legal services? ☐ YES ☐ NO

   If YES, please confirm the percentage of time spent providing these services. ____ %

SECTION M. Telehealth Services

1. Have you in the past or do you in the future intend to use any of the following platforms to offer medical advice to any of your patients?

☐ WhatsApp ☐ Email ☐ Telephone ☐ Skype ☐ Medici ☐ Other (please specify) _____

2. Where telehealth is being practiced would you ever offer medical advice to a patient with whom you have never previously had a physical consult? ☐ YES ☐ NO
3. Do you insist that there has been a physical consultation between the patient and yourself within at least a 12 month period prior to the telehealth/virtual consultation taking place? ☐ YES ☐ NO
4. How do you issue prescriptions following a telehealth / virtual consultation?

☐ WhatsApp ☐ Email ☐ Telephone ☐ Skype ☐ Medici ☐ Other (please specify) _____

5. What is the current system you use to capture patient notes from a telehealth / virtual consultation?

☐ Manual capture ☐ Electronic capture ☐ Other (please specify) _____

6. Do you always bill the patient/s for the telehealth / virtual consultations? ☐ YES ☐ NO
7. Do you ensure that specific informed consent for Telehealth Services is obtained (digital signatures from patient/user is included)? ☐ YES ☐ NO

SECTION N. HIV-Protection

1. Do you require access to HIV testing and treatment in the event of possible exposure? ☐ YES ☐ NO

SECTION O. Insurance quotation required

1. Please indicate the amount of cover you require. R _____

SECTION P. Supporting Information Record

1. Has any medical malpractice insurer ever declined or repudiated a claim, or not paid a claim in full (other than by application of an Excess), due to your non-disclosure of material information or breach of the insurance policy? ☐ YES ☐ NO

   If YES, please provide details _____

2. Has a medical malpractice insurer ever declined to renew your policy or requested you to seek insurance cover elsewhere? ☐ YES ☐ NO

   If YES, please provide details _____

3. If you have previously had a successful malpractice claim made against you by a patient, did you put procedures in place to prevent a recurrence of the circumstances that gave rise to the claim or loss?

   ☐ YES ☐ NO , I have never had a successful claim made against me.

4. Have you ever had:

	YES	NO	If YES, please provide details
Any hospital privileges restricted or suspended, whether voluntarily or involuntarily?	☐	☐	
Any licence to practice and/or dispense drugs or medication revoked, suspended or limited in any way?	☐	☐	
Your registration with any professional body or association refused, withdrawn or made conditional?	☐	☐	
Conditions imposed on your practice, been suspended or removed from a medical register due to a complaint, inquiry or investigation, or been declared an "impaired physician" or fined by the HPCSA or another regulatory body?	☐	☐	

5. Are you currently under investigation by any hospital, other medical facility or regulatory body for any reason? ☐ YES ☐ NO

If YES, please provide details

6. Do you have formal procedures in place for dealing with patient complaints? ☐ YES ☐ NO

7. Do you ensure that all volunteers or students working at your practice are suitably qualified to provide the relevant health care services or are under the direct supervision of a suitably qualified medical practitioner at all times when providing such services? ☐ YES ☐ NO ☐ N/A

8. Do you have procedures in place that comply with all applicable current regulations in respect of the sterilisation of instruments and the safe collection, storage and disposal of all waste including but not limited to sharps, dressings, blood products and other hazardous waste? ☐ YES ☐ NO ☐ N/A

9. Please disclose any other information that you consider to be material in relation to the risks to be insured under this policy which have not been covered in the proposal form or this questionnaire.

SECTION Q. Addendum

Are you a: ☐ procedural practitioner ☐ non-procedural practitioner

Dentistry and Orthodontics

Please indicate the breakdown of your procedures in an average year as follows:

Area	% Split	Area	% Split	Area	% Split
Aesthetics and Cosmetic Dentistry		Anaesthesia/Sedation		Botox or other facial cosmetics	
General Dentistry		Implantology		Oral Surgery	
Surgical Periodontal Treatment		Other (please specify)			

Please indicate below which of the below aesthetic and cosmetic procedures you currently perform, (if any) and on average how many are performed per annum:

Procedure	Y/N	No. Performed	Procedure	Y/N	No. Performed	Procedure	Y/N	No. Performed
Botox Injections			Dental Implants			Teeth Whitening		
Bridges			Dermal Fillers			Veneers		
Ceramic Fillings			Facial Aesthetics			Other (please specify)		
Composite Bonding			Gum Contouring					
Crowns			Inlays and Onlays					

General Practitioners

Please indicate the breakdown of your procedures in an average year as follows:

Area	% Split	Area	% Split	Area	% Split
Accident & Emergency		Detailed Pregnancy scans		Procedural (incl basic scans; excl obstetrics)	
Anaesthetics		Obstetrics		Surgical Assistance in Theatre	
Cosmetic & Aesthetic		Minor Procedures performed in rooms			

Pharmacists

Please indicate the category you fall into and require cover for:

Industrial Management, Group Directors, Primary Care Dispensing Therapist (PCDT), RESPONSIBLE PHARMACIST	YES	NO
Retail/Hospital/Industrial Pharmacist, Quality Assurance and Regulatory Affairs Pharmacist, Locum, Pharmacy/Wound care Nurse, Medical Scheme Clinical Consultant, Wholesaler/Distributor Pharmacist, Other	YES	NO
Pharmacy Technician	YES	NO
Pharmacist's Assistant, Intern, Academic, Community Service Pharmacist)	YES	NO
Pharmacy Student, Pharmacy Technician Trainee and Students	YES	NO

1. Accident and Emergency Work

1.1 Please indicate any additional training received, including fellowships.

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

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

2. 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

3. Address of the Accident and Emergency unit/s:

4. Will there be a senior doctor present at all times? YES NO

2. Cosmetic & Aesthetic work

Please confirm which (if any) of the following procedures are performed and on average how many are performed per annum (please also add in any procedures not included in the list below):

	Y/N	No. Performed		Y/N	No. Performed
Botox Injections			Lipolytic Liposuction		
Chemical peel			Microdermabrasion		
Cosmetic tattooing			Permanent makeup		
Fillers			Sclerotherapy/Smart Lipo		

Laser hair removal			Threads		
Laser wrinkle removal			Other (please specify)		

Additional Information pertaining to Cosmetic & Aesthetic work:

2.1. All products used for the Cosmetic & Aesthetic procedures are approved by South African Health Products Regulatory Authority (SAHPRA) ☐ YES ☐ NO

2.2. Please state your relevant qualifications and experience relating to the Cosmetic & Aesthetic procedures to be performed:

Qualifications	Institution	Year achieved

2.3.1. Is it mandatory that all your patients sign consent for such procedures? ☐ YES ☐ NO

2.3.2. If NO, please provide details on how consent is taken for these procedures.

3. Surgical Assistance

1. Do you provide surgical assistance? ☐ YES ☐ NO

   If YES, please complete the following:

- Do you assist with obstetric, neurosurgical and spinal or bariatric cases? If YES, please specify. ☐ YES ☐ NO
- Is your assistance limited to holding instruments in theatre? ☐ YES ☐ NO

  If NO, please provide as much detail as possible (e.g. provide post-operative care, perform surgical closure).
- How many surgeons do you assist regularly? Past ☐ Coming ☐
- On average, in how many procedures per annum do you act as an assistant surgeon? Past ☐ Coming ☐
- Do you treat children (12 years of age or younger)? ☐ YES ☐ NO
- If YES, what percentage of your patient base do they represent? Past ☐ % Coming ☐ %

Important Notice

Before you enter into a contract of insurance with an Insurer, you have a duty to disclose to the Insurer every matter that you know, or could reasonably be expected to know, this is relevant to the Insurer's decision whether to accept the risk of the insurance, and, if so, on what terms.

You have the same duty to disclose those matters to the Insurer before you renew, extend, vary or reinstate the contract of insurance.

It is important that all information contained in this proposal is understood by you and is correct, as you will be bound by your answers and by the information provided by you in this proposal. You should obtain advice before you sign this proposal if you do not properly understand any part of it.

Your duty of disclosure continues after the proposal has been completed up until the contract of insurance is entered into.

Declaration

I/We the undersigned duly authorised person(s) declare that:

1. I am/we are authorised by each of the Insureds to sign this Proposal Form.
2. The above statements are correct, true and complete.
3. No information material to this Proposal Form has been withheld.
4. I/we have read the important facts which you have put before me/us and I/we understand the advice given in relation to the duty of disclosure.
5. I/we have diligently made all necessary and detailed enquiries in order to comply with the duty of disclosure.
6. Apart from what is disclosed in this document, I/we are not aware of any request for records being made by a patient, family member of a patient, or an attorney nor have I/we received a letter from an attorney regarding treatment which was provided to a patient.
7. Apart from what is disclosed in this document, I/we are not aware of any circumstance which might reasonably lead to a claim or suit being lodged against me, regardless of whether I/we view that suit to be without merit.
8. I/we understand that no insurance is in force until such time as the Insurer has confirmed acceptance of the proposed insurance.
9. I/we undertake to inform the Insurer of any material change to these facts occurring before/after completion of the contract of insurance.
10. I/we acknowledge that the Insurer relies on the information and representations in this Proposal Form and otherwise made by me/us in relation to this insurance.
11. I/we acknowledge that the signing of this proposal form binds neither myself to accept the subsequent quote, 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.
12. Except where indicated to the contrary, I/we understand that any statement made in this Proposal Form will be treated by the Insurer as a statement made by all persons to be insured.

Signed _____ Date _____

Note: We recommend that you keep a record, including copies of letters and this Proposal Form, of all information supplied to us for the purpose of entering into this contract.