

# Medical Malpractice Insurance Proposal Form for Specialist Medical Practitioners



Authorised Financial Services Provider • FSP Number 38225



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.
- You acknowledge that the personal information you supply is provided voluntarily and therefore constitutes specific, voluntary consent to the processing of such information by Genoa / Safire. Your personal information will be processed for: -
  - a. General and specific underwriting and risk assessment purposes;
  - b. Statistical research and / or reporting;
  - c. the legitimate interests of Genoa / Safire and / or yourself; and
  - d. any statutory or regulatory compliance (where applicable).
- You have the right to request access to, and correction of, your personal information. You can instruct Genoa / Safire to cease the processing of your personal information at any time and, subject to the requirements of applicable South African law, request that Genoa / Safire delete and/or de-identify such personal information.

#### 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	<input type="text"/>		
2. ID number	<input type="text"/>	5. Country of permanent residence	<input type="text"/>
3. Mobile number	<input type="text"/>	6. Email address	<input type="text"/>
4. Work Number	<input type="text"/>	7. Website	<input type="text"/>

**SECTION B. Practice Details**

1. Practice address	<input type="text"/>		
2. Telephone number	<input type="text"/>	6. How long have you been practicing?	<input type="text"/>
3. VAT number (if applicable)	<input type="text"/>	7. How long have you been practicing as a specialist?	<input type="text"/>
4. HPCSA registration number	<input type="text"/>		
5. Practice Number (PCNS)	<input type="text"/>		

**SECTION C. Professional credentials**

1. Please state your relevant qualifications and experience

Qualification(s)	Institution	Year achieved
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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. What professional organisations or associations are you currently a member of?

4. Are you currently registered with the HPCSA as a specialist?  YES  NO  
Please indicate your specialty and all applicable sub-specialties

Speciality	Sub- speciality
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

5. 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:

		%
		%
		%
		%
<b>TOTAL</b>		<b>100%</b>

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:

**3. For all practitioners:**

1. Do you provide chronic pain management?  YES  NO  
If YES, please provide us with details regarding the chronic pain management provided.

2. Do you perform Radiofrequency Ablation?  YES  NO  
If YES, please provide a copy of your certificate of training and/or a list of courses attended.

**4. For anyone performing surgical procedures:**

1. Do you treat children (12 years of age or younger)?  YES  NO  
If YES to the above, do you keep minors records until they turn 21?  YES  NO

2. Do you perform any cosmetic procedures?  YES  NO

3. Do you perform laparoscopic or arthroscopic surgery?  YES  NO

If YES to the above, how many of these procedures do you perform per annum?

a. Have you received any additional training in this field (e.g. medical residence or fellowship programs)?  YES  NO

If YES, please specify.

4. Do you perform any spinal procedures?  YES  NO  
If YES, please confirm whether you perform basic spinal procedures or minimally invasive spinal surgery.

**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	<input type="text"/>	Previous year's premium	<input type="text"/>
Limit of Indemnity	<input type="text"/>	Renewal date	<input type="text"/>
Excess	<input type="text"/>	Retroactive date*	<input type="text"/>

\* 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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	<input type="text"/>	<input type="text"/>
Government practice	<input type="text"/>	<input type="text"/>
Medico-legal Services	<input type="text"/>	<input type="text"/>

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. 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 M. 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 N. Insurance quotation required**

1. Please indicate the amount of cover you require.

**SECTION O. 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 P. Addendum**

**Obstetrics/Gynaecology/Maternity**

Do you undertake obstetrics procedures?  YES  NO

Please provide details of the number of the following procedures (if any) done per annum in the following categories:

	Previous financial year	Current financial year
Number of vaginal deliveries conducted	<input type="text"/>	<input type="text"/>
Number caesarean deliveries conducted	<input type="text"/>	<input type="text"/>
Number of vaginal deliveries conducted for patients who previously had a caesarean	<input type="text"/>	<input type="text"/>
Number of pregnancy ultrasounds conducted	<input type="text"/>	<input type="text"/>
Number of laparoscopic surgeries conducted	<input type="text"/>	<input type="text"/>
Number of vaginal surgeries conducted (including hysterectomies)	<input type="text"/>	<input type="text"/>
Number of open surgeries	<input type="text"/>	<input type="text"/>

Please provide us with the breakdown of births done below:

Average number of deliveries per year Single birth  Multiple births  Stillborn

Have you done any post-graduate training and/or have specialist qualification for the following procedures and, if so, please provide details:

Procedure	Post-graduate training and/or have specialist qualification - if YES, please supply details	
Pregnancy ultrasounds	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="text"/>
Laparoscopic surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="text"/>

Do you (or a suitably qualified locum who you appoint in the event that you are unavailable):

- Ensure ongoing foetal monitoring readings periodically during labour or delivery?  YES  NO
- Ensure continuous electronic foetal monitoring performed on all patients in active labour?  YES  NO
- Personally approve the ordering, and supervise the use, of oxytocic drugs?  YES  NO
- Ensure that an obstetrician is available for patients 24 hours per day?  YES  NO
- Ensure that you are able to perform a caesarean section within 30 minutes, 24 hours a day?  YES  NO
- Regularly perform deliveries outside of the hospital?  YES  NO
- Follow the SASOG BetterObs Programme and SASOG protocols?  YES  NO

**Ophthalmologists**

1. Does your practice perform eye care of premature infants at risk of/with established ROP?  YES  NO
2. Do you perform any Laser refractive surgery?  YES  NO  
If YES, How many of these procedures do you perform per annum?
3. Do you perform oculoplastic procedures for cosmetic rather than functional reasons?  YES  NO

**Plastic and Reconstructive Surgeons**

1. 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?
2. If cosmetic procedures are performed, please confirm which (if any) of the following procedures are performed and on average how many are performed per annum:

Procedure Performed	Y/N	No. Performed	Procedure	Y/N	No. Performed	Procedure	Y/N	No.
a. Botox Injections	<input type="checkbox"/>	<input type="text"/>	b. Chemical peel	<input type="checkbox"/>	<input type="text"/>	c. Cosmetic Tattooing	<input type="checkbox"/>	<input type="text"/>
d. Fillers	<input type="checkbox"/>	<input type="text"/>	e. Laser hair removal	<input type="checkbox"/>	<input type="text"/>	f. Laser wrinkle removal	<input type="checkbox"/>	<input type="text"/>
g. Microdermabrasion	<input type="checkbox"/>	<input type="text"/>	h. Permanent makeup	<input type="checkbox"/>	<input type="text"/>	i. Sclerotherapy/ Smart	<input type="checkbox"/>	<input type="text"/>
j. Lipo Threads	<input type="checkbox"/>	<input type="text"/>	k. Breast Enhancement: Augmentation, Lift, Reduction	<input type="checkbox"/>	<input type="text"/>	l. Facial Contouring: Rhinoplasty, Chin or Cheek Enhancement	<input type="checkbox"/>	<input type="text"/>
m. Facial Rejuvenation: Facelift, Eyelid Lift, Neck Lift, Brow Lift	<input type="checkbox"/>	<input type="text"/>	n. Body Contouring: Tummy Tuck, Lipolytic Liposuction	<input type="checkbox"/>	<input type="text"/>			

### Paediatricians

- Do you treat infants
  - after the first 7 days of life; or
  - in the first 7 days of life exclusively in an office-based or outpatient setting; or
  - in the first 28 days of life?
- Do you attend to deliveries?
- Do you look after neonates in the ICU?
- Does the Neonatal ICU centre at which you attend, have advanced technology to provide specialised treatment?

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

### Surgery

- In-theatre surgical procedures:
  - How many procedures do you perform on average per annum as primary surgeon? Past year  Coming year
  - How many procedures per annum do you act as an assistant surgeon? Past year  Coming year
- If you only provide surgical assistance (as opposed to acting as the primary surgeon), please complete the following:
  - 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):



## 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.