

## DAY SURGERY PROFESSIONAL INDEMNITY APPLICATION



**Important Facts Relating To This Proposal Form** - You should read the following advice before proceeding to complete this proposal form.

Medisure Indemnity Australia Pty Ltd (ABN 29 116 319 567) AFS Licensee #412681 arranges the insurance

**The proposed insurance is issued on a 'claims made' basis.**

This means that the policy responds to:

1. claims first made against the insured during the policy period and notified to the Insurer during that policy period, providing that the insured was not aware, at any time prior to the policy inception, of circumstances which would have alerted a reasonable person in the insured's position that a claim may be made against the insured; and

2. 'claims circumstances' notified pursuant to Section 40 (3) of the Insurance Contracts Act which states:

'where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of the claim, when made, by reason only that it was made after the expiration of the period of insurance cover provided by the contract'.

After policy expiry, no new claims can be made on the expired policy even though the event giving rise to the claim may have occurred during the policy period. If during the policy period you become aware of circumstances which a reasonable person in your position would consider may give rise to a claim, and which you fail to notify to us during the policy period, we may not cover you under a subsequent policy for any claim which arises from these circumstances.

When completing the proposal you are obliged to report and provide full details of all circumstances of which you are aware and which a reasonable person in your position would consider may give rise to a claim.

It is important that you make proper disclosure (see Duty of Disclosure, below) so that your cover under any new policy with us is not compromised.

Pursuant to the Insurance Contracts Act your duty to disclose all relevant information is set out below.

**Duty of Disclosure**

Before entering into a contract of general insurance, you have a duty, under the Insurance Contracts Act, to disclose to us every matter that you are aware of, or could reasonably be expected to be aware of, that is relevant to our decision about insuring you and if so, on what terms. You have the same duty to disclose these matters to us before you renew, extend, vary or reinstate a contract of general insurance. Your duty however does not require disclosure of matter -

- that diminishes the risk to be undertaken by us;
- that is of common knowledge;
- that we know or, in the ordinary course of our business, ought to know;
- as to which compliance with your duty is waived by us.

You should note that your duty continues after the proposal form has been completed until the policy is entered into, i.e. until the date we receive instructions to bind cover.

**Non-disclosure**

If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the policy in respect of a claim or may cancel the policy. If your non-disclosure is fraudulent, we may also have the option of avoiding the contract from its beginning. It is therefore vital that you enquire of all entities comprising the insured, including senior staff, before completing the proposal form and before you sign any declaration confirming no change in the information disclosed.

**Retroactive Liability**

The proposed insurance may be limited by a retroactive date either stated in the schedule or endorsed onto the policy. Where the retroactive cover provided by the proposed policy is subject to such a date, then the policy does not cover any claim arising from actual or alleged act, error, omission or conduct occurring prior to such retroactive date.

**Average Provision**

One of the insuring provisions of the proposed insurance may provide that where the amount required to dispose of a claim exceeds the limit of the sum insured in the policy then the Insurer shall be liable only for a proportion of the total costs and expenses. This shall be the same proportion of the total expenses as the policy limit bears to the total amount required to dispose of the claim.

**Surrender of Waiver of any Right of Contribution or Indemnity**

If another person or company is liable to compensate you or hold you harmless for part or all of any loss or damage otherwise covered by our policy, but you agree with that person or company (either before or after the inception of our policy) that you would not seek to recover any loss or damage from them, we will not cover you for this loss or damage.

## BROKER DETAILS

BROKER / INSURANCE AGENT:

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ACCOUNT MANAGER

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ACCOUNT MANAGER CONTACT DETAILS

Email:		Phone #	
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## APPLICATION

**Name and ABN of proposed business to be insured (please list all entities to be insured)**

*\* Please also identify which entity leases property, employs staff, manages operations of the hospital where applicable*

	ABN	
	ABN	
	ABN	

**Primary address and additional locations**

Address					
Suburb		State		P/Code	
Contact Phone		Mobile			
Email					

**Location 1**

Address					
Suburb		State		P/Code	

**Location 2**

Address					
Suburb		State		P/Code	

**Location 3**

Address					
Suburb		State		P/Code	

**Postal Address (If different from above)**

Address					
Suburb		State		P/Code	

Names of all Partners Principals Directors	Qualifications	Date Qualified	Start Date: This Practice

## ACTIVITIES

Type of work	%	Type of work	%	Type of Work	%
Endoscopy		Urology		Termination of Pregnancy	
Gastroenterology		Laparoscopic		Lap Banding	
Ear, nose and throat		Cardiac		Ophthalmology	
Dermatology		Orthopaedic		ICU/Emergency	
General surgery		Orthopaedic Spinal		Medical Imaging	
Gynaecology		Oral/dental/maxillofacial			
In vitro fertilisation		Paediatric			
Haematology/Oncology		Obstetrics/Maternity (Give Details)			
Clinical Trials		Casualty/Emergency/Intensive Care			
Cosmetic – Elective/Plastic		Other (Please provide details below)			
Cosmetic - Reconstructive		<b>Total - 100%</b>			

Details if required for above

## STAFF DETAILS

Please list Staff Numbers by Category	Total Number	Employed	Contracted	Room Hire (No Nursing or Admin Provided)	Room Hire with Nursing and Admin Services
Partners / Principals / Directors (Non Surgical)					
Non-technical administrative staff					
Medical Practitioners/Surgeons					
Anaesthetists					
Nursing Staff (excl midwives)					
Radiographers/Sonographers, X-Ray Technicians					
Dentists					
Nursing/Personal Care Assistants					
Allied Health (please specify below)					
Midwives					
Other staff (please specify below)					
Trainee staff					
<b>Details of Staff if Required:</b>					

## FINANCIAL INFORMATION

Please list	Last Financial Year	This Year (to date)	Expected Next Year
Wages (excluding Medical Practitioners)	\$	\$	\$
Turnover/Gross Income (before any expenses)	\$	\$	\$

## GENERAL INFORMATION

If patients stay overnight at the insureds establishment, please provide the total number and average daily occupancy for the following:

	Number	Average daily occupancy
(a) Beds	#	#
(b) Bassinettes/cribs/cots	#	#

What arrangements do you have to assist you during your temporary absence on business, leave or sickness, or unforeseen emergency?

Has your practice undergone any mergers or acquisitions?

Yes (Give Details)

No

Is any Partner, Principal or Director connected or associated (financially or otherwise) with any other practice or business?

Yes (Give Details)

No

Please list the professional bodies or associations to which the Applicant belongs:

Does any contract/client represent more than 50% of your annual work or fees?

Yes (Give Details)

No

Do you engage consultants, contractors or agents?

Yes

No

(a) do you insist they carry their own Professional Indemnity or Malpractice Insurance?

Yes

No

(b) do you enter into any hold-harmless agreements or otherwise waive any legal rights or entitlements which you may have against such consultants, sub-contractors or agents?

Yes

No

Do you envisage any substantial changes in your activities over the next 12 months?

Yes (Give Details)

No

Do you perform work outside of Australia, or work for clients located overseas?

Yes (Give Details)

No

Please provide the approximate percentage of your activities (based on fee income) applicable to each State or Territory.

NSW	VIC	QLD	SA	WA	TAS	NT	ACT
%	%	%	%	%	%	%	%

Does the Practice presently carry, or has the Practice ever carried, Professional Indemnity Insurance or Malpractice Insurance?

Yes (Give Details)

No

Insurer		Expiry Date	
Limit of Indemnity		Premium (\$)	

What Limit of Indemnity would you like to apply for? (please tick)

\$1 million
  \$2 million
  \$5 million
  \$10 million
  \$20 million
  Other:

## CLAIMS HISTORY

**Have you, the company or any Partner, Principal, Director or Staff Member ever:**

1. been refused any form of professional indemnity cover or had an application declined or special conditions imposed?
2. had your registration revoked, suspended or had conditions placed upon it, or have you ever been found guilty of any offence in relation to your practice?
3. Had any claims for malpractice, negligence or breach of professional duty been made in the last ten (10) years against the Practice or any of their predecessors in business or any prior practice of any of their present or former Partners, Principals or Directors, or have circumstances been notified to insurers that might give rise to a claim?  Yes **(Give Details overleaf)**  No

**Are you aware of any:**

1. Previously unreported incidents or circumstances from your health care activities within the past 5 years that could lead to a future complaint, claim or legal action?
2. Any Partner, Principal, Director, or staff member that has ever been subject to disciplinary proceedings for professional misconduct?  Yes **(Give Details)**  No

Date of Claim:		Notified to Insurer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurer (If any)	
Brief Description of Matter/Circumstance:					
Name of Claimant or Potential Claimant					
Amount Paid or Estimate of Potential Liability	\$	Is the matter Finalised or Outstanding?			

Date of Claim:		Notified to Insurer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurer (If any)	
Brief Description of Matter/Circumstance:					
Name of Claimant or Potential Claimant					
Amount Paid or Estimate of Potential Liability	\$	Is the matter Finalised or Outstanding?			

## DECLARATION

- (a) I/We declare that all answers and statements made in the application are true, correct and complete in every respect.
- (b) I/We authorise the Insurer to give to or obtain from other insurers or insurance reference bureaus or credit reporting agencies, any information about this insurance or any other insurance of mine including this completed application and my insurance claims history and my credit history.

Organisation / Practice Name:			
Signed (Principal / Practice Manager)		Date:	

**Please return your completed proposal form to your broker**

Medisure Indemnity Australia Pty Ltd  
**If you require assistance please contact your broker**