Practitioner Indemnity Insurance Policy Application Form

Avant Mutual Group Limited
ABN 58 123 154 898

Membership with Avant Mutual Group Limited ABN 58 123 154 898
Practitioner Indemnity Insurance with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765
Version: January 2016

Office use only: Campaign code:

This is the application form for Membership and a Practitioner Indemnity Insurance Policy. This is a legal document, which will form (a) the basis of the contract of insurance between the insured (you) and Avant Insurance Limited (Avant Insurance); and (b) the basis of your contract of Membership with Avant Mutual Group Limited (Avant). When reading this document a reference to 'we', 'our' and 'us' will mean Avant Insurance. 'You' and 'your' will mean the insured.

It is important that the information you provide is complete and accurate. Where there is not sufficient space please provide your answers within the 'additional information' section or on a separate page. If you fail to disclose material information we may be entitled to reduce our liability or avoid the contract from the beginning. Once we receive your completed application we will assess to determine if you meet our underwriting criteria.

By submitting this form or otherwise providing your personal information to Avant you consent to your personal information being collected, held, used and disclosed by Avant in accordance with the Avant Privacy Policy found at **avant.org.au/Privacy-Policy**.

If you have any queries or need to access policy documents you can access them online at avant.org.au or contact Member Services on 1800 128 268.

Contact information

Title:	Given names:	Last name:
Gender: ○ Male ○ Female		Date of birth:
Residential address:		Telephone:
		Fax:
		Mobile:
Primary practice address:		Practice telephone:
Preferred mailing address: ○ Residential ○ Practice ○ Other (provide details below)		
Email address:		Alternative email:

Electronic communications disclosure and consent

Do you agree to receive the Product Disclosure Statement, Financial Services Guide and renewal documentation in future years electronically? **Note: You may alter these consents at any time.** ○ **Yes** ○ **No**

Do you agree to receive electronic communications from Avant, such as specialist medico-legal bulletins, risk education and e-learning bulletins, and product updates and offers that may be of interest to you? ○ **Yes** ○ **No**

Financial Reports

Avant's Financial Reports will only be made available to members at avant.org.au unless you elect to be sent a copy.

Please indicate how you would like to receive Avant's financial reports: ○ **at avant.org.au** ○ **via email** ○ **by post**

Qualifications and registration information

1. Please list your medical qualifications:

Qualification:	University/institution:	Year awarded:	Country:

2. Please list your current college membership:

College:	Date membership commenced:

Avant INSURANCE
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3. Do you require a 422 or 457 visa to work in Australia? ○ Yes ○ No

If **YES** please indicate which visa and **attach a copy** ○ 422 ○ 457

4. Please provide your AHPRA registration details:

First year of registration:	Registration number:

5. In relation to your registration in any country, have you ever been refused registration, suspended or deregistered? ○ Yes ○ No

If **YES** please provide details in the 'additional information' section or on a separate page.

6. In relation to your registration in any country, are there or have there been any conditions, limitations, notations or undertakings imposed? ○ Yes ○ No

If **YES** please provide details in the 'additional information' section or on a separate page.

7. Which month and year did you complete your fellowship training?

Month:	Year:

Claims, complaints, incidents or proceedings

8. Have you ever been subject to an investigation, complaint, inquiry (including Medicare inquiry), coronial inquest or proceeding in relation to your conduct as a healthcare professional? ○ Yes ○ No

9. Have you (or a practice in which you work or worked) ever been involved in any claims, demands, suits or other legal actions in connection with your conduct as a healthcare professional? ○ Yes ○ No

If you answer YES to question 9 please provide the following additional information; date notified to MDO/Insurer, name of MDO/Insurer, claim number, name of claimant/patient, name of Hospital/Practice, amount paid to date, estimated MDO/Insurer outstanding reserve and details of the claim.

10. Are you aware of any act, error, omission or circumstance in respect of your conduct as a healthcare professional that was or could have been notified under any insurance policy that was or is in force prior to the inception of this policy or which may give rise to a claim, complaint or other action being brought against you? ○ Yes ○ No

If you answer YES to question 10, please provide the following additional information; date notified to MDO/Insurer, name of MDO/Insurer, claim number, name of claimant/patient, name of Hospital/Practice, amount paid to date, estimate of potential liability and details of the claim.

11. Have you ever been diagnosed with or treated for cognitive impairment or any other health conditions that may affect your performance as a healthcare professional? ○ Yes ○ No

12. Have you ever been charged with, convicted or found guilty of a criminal offence in any country? ○ Yes ○ No

13. Have you ever made a self notification or been the subject of a voluntary notification to AHPRA? ○ Yes ○ No

14. Have you ever been counselled, disciplined or had authorisations altered by an employer, a hospital, an area health authority, a medical college, a statutory body or a medical board? ○ Yes ○ No

15. Have you ever been involved in or are you aware of any matter or potential matter that would be covered by this policy, including any potential defamation dispute, employer or employee dispute or audit by the Australian Tax Office? ○ Yes ○ No

If you answer **YES** to any questions, please provide details in the 'additional information' section or on a separate page.

Policy details

16. **Policy start date:** If your application is approved, your cover will start from the **date we approve your application**, unless you request a later start date. Do you want the policy to start at a later date? ○ Yes ○ No

If **YES** please specify date

17. **Policy end date:** When would you like this policy to end? ○ 30 June ○ 31 December

18. Do you want to participate in the Premium Support Scheme? ○ Yes ○ No

If **YES** we will send you a Premium Support Scheme Terms and Conditions booklet (PSS booklet) and Premium Support Scheme Request Form if we send you an offer of insurance. Please refer to our PSS booklet for details of the eligibility criteria. You can access the booklet online at avant.org.au or by requesting a copy from Member Services on 1800 128 268.

Medical practice information

19. What is your Category of Practice?

Category of Practice: Are you a staff specialist? ○ Yes ○ No

Please refer to the Category of Practice Guide to identify the category that covers your practice. Failure to do so will result in no cover for a procedure outside of your chosen category.

20. Have you participated, or are you participating in a clinical trial where you are working directly for, or on behalf of a pharmaceutical company? ○ Yes ○ No

21. Please provide your estimated gross billings* for private practice: $

22. Please confirm what period you are providing an estimate for:

○ 12 months

○ end of proposed policy (to 30 June or 31 December) Note: We will annualise these billings.

***Estimated gross billings: Please read the definition of gross billings in the Category of Practice Guide. You must provide an accurate estimate of your gross billings. Otherwise you may not be covered in the event of a claim against you.**

23. Are you a Visiting Medical Officer / Contractor? ○ Yes ○ No

24. Do you provide healthcare services to public patients where you are **NOT** or do not have the right to be indemnified by a hospital, area health service, government scheme, or another person and require cover for healthcare you provide to public patients? ○ Yes ○ No

If **YES** please provide details in the 'additional information' section or on a separate page of the workplace where you will be treating public patients. You need to determine if you are entitled to cover for civil liability for public patients from a hospital, area health service, government scheme, or another person (this cover relates to civil liability for treating public patients only and does not impact other cover under the policy).

If **YES** please also provide estimated gross billings* for the same period: $

25. Are you practicing in an area classified as Rural Remote Metropolitan Area (RRMA) 3-7 by the Department of Health and Ageing? ○ Yes ○ No

26. Do you provide any healthcare which would not normally fall within the scope of your speciality? ○ Yes ○ No

Do you require indemnity from Avant for this work? ○ Yes ○ No

Please indicate the type of work, gross billings or income related to this work.

Type of work:	Gross billing/income:

27. Have you changed your category of practice or billings in the last 5 years? ○ Yes ○ No

Year:	Speciality:	Annual billings:

28. Have you changed your location in the last 5 years? ○ Yes ○ No

Year:	Location:

Location is defined as Hospital, State, Area Health Service or Country

29. Do you currently supervise registrars? ○ Yes ○ No

30. Are you a practice owner? ○ Yes ○ No

Past insurance and indemnity information

31. Have you ever been indemnified by any Australian medical defence organisation or insurance company in the past? ○ Yes ○ No

If **YES** please provide details:

Insurer/organisation:	Policy period:	Why is cover being sought elsewhere?	Retroactive date:

32. Have you ever had an application or renewal for professional indemnity insurance refused, had a loading, deductible or special condition placed on your insurance or been offered or provided with a reduced level of cover, had your application declined, or had your policy cancelled? ○ Yes ○ No

If **YES** please provide details in the 'additional information' section or on a separate page.

Retroactive indemnity

As required by section 22 of the **Medical Indemnity (Prudential Supervision and Product Standards) Act 2003**, if your application is accepted, **we will** offer you retroactive cover when this insurance contract is entered into, comes into effect or is renewed. Retroactive cover is protection for the healthcare you provided after your retroactive cover date and before the start date of your current medical indemnity insurance policy. This is subject to other exclusions in the policy, particularly the exclusion for 'known circumstances' **prior to the start of the policy period**, which should have been notified to another insurer.

Please nominate a retroactive cover date that covers all healthcare you have provided within Australia. This is usually the date you first registered with AHPRA. For more information visit avant.org.au/retroactive-cover

33. Nominated retroactive date:

34. Do you have any periods for which you require additional retroactive cover because you were not covered by an insurance policy or you returned to private practice after a period of no private practice or because you previously changed insurer and did not take out run off cover?

From:	To:
From:	To:

Optional covers

35. Do you wish to apply for personal expenses optional cover and interruption to earnings optional cover? This optional cover package is subject to an additional premium.

◯ **Yes** ◯ **No**

Before signing the declarations, please review the information you have provided and ensure that you have answered all sections accurately and to the best of your knowledge and belief.

Application and declaration

I hereby apply for membership of Avant and for a Practitioner Indemnity Insurance Policy from Avant Insurance. I agree to be bound by the Constitution of Avant and the terms of any insurance policy issued to me by Avant Insurance.

I declare that by signing, typing my name, or entering an electronic signature in the space provided and returning this form that:

a) the information I have given in this application form and in any accompanying documents is true and correct, and I understand that Avant Insurance will rely on this information in deciding whether to provide me with an insurance contract and on what terms and conditions, and that it will form the basis of my policy

b) the retroactive date I have selected is adequate to cover me for all prior uncovered incidents and I agree to accept all future offers of retroactive cover as set out in the Policy and this application form, unless I otherwise advise Avant Insurance in writing. If I decide not to accept any offer of retroactive cover or future offers of retroactive cover, I may be uninsured for incidents occurring prior to the commencement date of my policy

c) if I have asked for public patient cover I understand that I need to determine if I am entitled to cover for civil liability for public patients from a hospital, area health service, a government scheme, or another person and that cover for civil liability will only be provided to me where I have no right to indemnity

d) I understand my duty of disclosure exists until the contract of insurance is entered into and that I have a continuing obligation to inform Avant Insurance of any material alteration of the risk during the policy period – including any change in the nature or location of my practice or my billings (if any)

e) I have read and understood the Financial Services Guide, Product Disclosure Statement, Practitioner Indemnity Insurance Policy, Category of Practice Guide and Constitution of Avant and I acknowledge that cover is subject to the terms, conditions and exclusions of the Policy

f) I consent to Avant contacting me in accordance with Avant's Privacy Policy (including via email, if I have provided my email address). I understand that I may alter this consent at any time by contacting Avant

g) I understand this application is subject to approval by Avant and Avant Insurance. I acknowledge that if a contract of insurance is issued it will be subject to the terms and conditions of the policy provided to me or as otherwise specifically varied by Avant Insurance and agreed to by me

h) I authorise Avant Insurance to discuss and obtain information or documents in relation to insurance matters or claims history from another insurance company, MDO or an insurance reference bureau or similar organisation

i) I authorise Avant Insurance to obtain information and documents in relation to my registration, conditions of my registration or any other matter from any Medical Board or other registration body

j) I understand I may be required to participate in an audit to verify my category of practice and/or my gross private practice billings (if any) and that I must cooperate and facilitate such an audit. This may include the provision of a Statutory Declaration by me with regard to my gross billings for private practice.

Signature:	Date:
Print name:	

Additional information

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