



# Healthcare and Medical Malpractice Insurance Proposal Form

## IMPORTANT NOTICES

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 Pacific Indemnity Underwriting Solutions Pty Ltd 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 Pacific Indemnity Underwriting Solutions Pty Ltd 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.

### Wholesale only

Pacific Indemnity Underwriting Solutions Pty Ltd is only licensed to offer or provide General Insurance products or services which do not include any of the following types of General Insurance (which are defined by the Corporations Act as "retail"): Motor Vehicle, Home Building, Home Contents, Sickness and Accident, Consumer Credit, Travel, Personal or Domestic Property, Medical Indemnity or any other kind of General Insurance which has been prescribed by the Corporations Regulations.

### About Pacific Indemnity Underwriting Solutions Pty Ltd

Pacific Indemnity Underwriting Solutions Pty Ltd, ABN 14 606 511 639, specialises in Professional Risk insurance (including Professional Indemnity Insurance, Malpractice Insurance, Information & Computer Technology Insurance, Management Liability Insurance and similar products).

Pacific Indemnity's Australian Financial Service Licence number is 480863.

# Medical Malpractice Insurance Proposal Form

## 1. Details of Proposer

Full Legal Name(s) of each natural person & incorporated body to be insured, and any Trading Name(s)

ABN

Contact Person

Commencement Date of Business

Name(s) of any Legal Entity the Business has operated under other than those answered above)

Name(s) of any other business your Business has purchased, merged or consolidated with

## 2. Address

Street Address

Suburb

State

Postcode

Telephone

Postal Address (If different)

Email Address

Website

Number of Office Locations

Other Office Locations

## 3. Details of the proposed Insured's principals/partners/directors:

Name	Qualifications	Years as a principal of this practice	Years as a principal of prior practice	Name of prior practice in which you were a principal
<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. Number of full-time equivalent staff in the following categories:**

Surgeons	<input type="text"/>	Midwives	<input type="text"/>
Doctors	<input type="text"/>	Nurse Anaesthetists	<input type="text"/>
Anaesthetists	<input type="text"/>	Attendant Carers	<input type="text"/>
Dentists	<input type="text"/>	Dental Technicians	<input type="text"/>
Interns	<input type="text"/>	Undergraduate or student staff	<input type="text"/>
Medical Imaging technicians	<input type="text"/>	Other Medical, Health or allied employees (please specify below)	<input type="text"/>
Laboratory technicians	<input type="text"/>	<input type="text"/>	
Pharmacists	<input type="text"/>	Clerical / Administrative	<input type="text"/>
Registered Nurses	<input type="text"/>	Other Staff (please specify below)	<input type="text"/>
Enrolled Nurses	<input type="text"/>	<input type="text"/>	
		<b>Total</b>	<input type="text"/>

**5. Total amount of the Proposed Insured's turnover for the following periods:**

Turnover should also include income from joint ventures and fees attributable to sub-contractors and sub-consultants.

(a) Last 12 months (to date)	<input type="text" value="\$"/>
(b) Previous 12 months	<input type="text" value="\$"/>
(c) Next 12 months	<input type="text" value="\$"/>

**6. Details of Professional Services provided**

7. Have you previously undertaken any types of Professional Services which are not now undertaken *(If "Yes", please provide details)*

YES NO

8. Please provide patient percentages in the following categories:

Patient Category	%	Patient Category	%
Audiology	<input type="text" value=""/>	Optometry	<input type="text" value=""/>
Acupuncture	<input type="text" value=""/>	Oral and Maxillofacial Surgical	<input type="text" value=""/>
Allied Health Therapy (please specify below)	<input type="text" value=""/>	Paediatrics	<input type="text" value=""/>
Casualty / Emergency	<input type="text" value=""/>	Palliative	<input type="text" value=""/>
Chiropractic	<input type="text" value=""/>	Pathology	<input type="text" value=""/>
Day Surgery	<input type="text" value=""/>	Physiotherapy	<input type="text" value=""/>
Drug / Alcohol Dependency or Rehabilitation	<input type="text" value=""/>	Psychiatric	<input type="text" value=""/>
Elective Cosmetic	<input type="text" value=""/>	Radiology / Medical Imaging	<input type="text" value=""/>
General Dental and Orthodontics	<input type="text" value=""/>	Senile or Aged	<input type="text" value=""/>
General / Medical	<input type="text" value=""/>	Speech Pathology	<input type="text" value=""/>
Gynaecological	<input type="text" value=""/>	Podiatry Surgical (Minor)	<input type="text" value=""/>
IVF / Fertility	<input type="text" value=""/>	Surgical (Major)	<input type="text" value=""/>
Obstetrics / Maternity	<input type="text" value=""/>	Other (please specify below)	<input type="text" value=""/>
		<b>Total</b>	<b>100%</b>

**Allied Health and Other Additional Information**

**9. Please advise the Number of Beds per the following categories**

Category	Number of Beds	Category	Number of Beds
Intensive Care	<input type="text"/>	Other Hospital Beds	<input type="text"/>
Emergency / Casualty	<input type="text"/>	Nursing Home Beds	<input type="text"/>
Day Surgery	<input type="text"/>	Self-Care Units	<input type="text"/>
Maternity	<input type="text"/>	Other (please specify below)	<input type="text"/>
Children's Ward	<input type="text"/>	<input type="text"/>	
			<b>Total</b> <input type="text"/>

**10. Does the Proposer have any of the following?**

**Medical Imaging equipment (Cat Scanner, MRI etc)** YES NO

**Pathology Laboratory** YES NO

*If Yes to Pathology Laboratory, please advise the % of your total revenue in Question 5*  %

**11. Are any of the Proposed Insured's professional services performed outside of Australia or provided to clients based outside of Australia?** YES NO

*If "Yes", please give details of the name of the client(s), the country they are located within and what service(s) are provided*

Name of client(s)	Country	Services provided
<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"/>

**12. Does the Proposed Insured issue any brochures (or other promotional material)?** YES NO

*If "Yes", please attach copies of each.*

## Claims Information

- 13. After enquiry of the Partners/Principals/Directors and employees, has there been or is there now pending a claim against the Proposed Insured, its Subsidiaries, its predecessors in business or its current or former Partners/ Principals/Directors or employees for a Civil Liability in the performance of the Proposed Insured's Professional Services?** **YES** **NO**

*If "Yes", please give details*

Date of Claim	Details of each Claim	Claimant	Amount Paid and/or Outstanding
/ /			\$
/ /			\$
/ /			\$

- 14. After enquiry of the Partners/Principals/Directors and employees, is the Proposed Insured or any of its Subsidiaries aware of any circumstance or incident which may give rise to a claim against the Proposed Insured, its Subsidiaries or its Partners/ Principals/ Directors or employees?** **YES** **NO**

*If "Yes", please give details*

Name of Practice and/or Principal	Claimant	Details of each Claim	Amount Paid and/or Outstanding
			\$
			\$
			\$

- 15. After enquiry of the Partners/Principals/Directors and employees, is the Proposed Insured or any of its Subsidiaries aware of any prosecution or investigation (actual or pending) of the Proposed Insured, any Subsidiary, or any Partner / Principal/ Director or employees under any International, Commonwealth, State or Local statute, legislation, regulation or By Law?** **YES** **NO**

*If "Yes", please give details*

- 16. After enquiry of the Partners/Principals/Directors and employees, has the Proposed Insured, any Subsidiary or any Partner/Principal/Director or employee ever been subject to any disciplinary action, been fined or penalised, or been the subject of an inquiry investigating or alleging professional misconduct?** **YES** **NO**

*If "Yes", please give details*

## Details of Current Insurance

**17. As at today's date does the Proposed Insured have Professional Indemnity Insurance currently in force that has been paid for?** **YES** **NO**

*If "Yes", please state*

Insurer

Indemnity Limit

Expiry Date

Retroactive Date

**18. Has the Proposed Insured ever had any Insurer decline a proposal, imposed any special terms, cancelled or refused to renew a Professional Indemnity Insurance Policy?** **YES** **NO**

*If "Yes", please give details*

**19. Please advise the preferred Policy Limit and Excess**

### Policy limit

\$1,000,000	\$2,000,000	\$5,000,000	\$10,000,000
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Other	\$ <input style="width: 90%;" type="text"/>
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### Excess

\$2,000	\$5,000	\$10,000	\$20,000
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Other	\$ <input style="width: 90%;" type="text"/>
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## Stamp Duty

**20. For the purpose of calculating Stamp Duty please state the percentage of the Proposed Insured's gross income/fees that was earned in each state in the last 12 months:**

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Overseas	Total
<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %	<input style="width: 80%;" type="text"/> %

*\*If "Yes" to overseas operations, please give details of the overseas work*



## Additional information and accompanying documents

Please provide any additional information that is material to this application and list any accompanying documents below.

## Declaration

I/We hereby declare that:

My/Our attention has been drawn to the Important Notice accompanying this Proposal form and further I/we have read these notices carefully and acknowledge my/our understanding of their content by my/our signature/s below.

The above statements are true, and I/we have not suppressed or mis-stated any facts and should any information given by me/us alter between the date of this Proposal form and the inception date of the insurance to which this Proposal relates I/we shall give immediately notice thereof.

I/we agree that, by submitting this form, the personal information I/we provide to Pacific Indemnity Underwriting Solutions Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in the Pacific Indemnity Privacy Policy including for processing this application and providing me/us with cover.

I/We also confirm that the undersigned is/are authorised to act for and on behalf of all persons who may be entitled to indemnity under any policy which may be issued pursuant to this Proposal form and I/we complete this Proposal form on their behalf.

**To be signed by the Chairman/President/Managing Partner/Managing Director/Principal of the association/partnership/company/practice/business.**

Name:

Title:

Signature:

Date:

It is important the signatory/signatories to the Declaration is/are fully aware of the scope of this insurance so that all questions can be answered. If in doubt, please contact your insurance broker since non-disclosure may affect an Insured's right of recovery under the policy or lead to it being avoided.