MEDICAL MALPRACTICE PROPOSAL FORM FOR AMBULANCE SERVICES

Hollard.

Please answer ALL questions fully. If the space provided is insufficient, a separate sheet should be attached.

The Declaration forming part of this Proposal must be signed by a Partner in the Practice and where cover is to include any Company through which the Practice provides professional services, the partner signing the Declaration shall be deemed to be the duly authorised agent of such company.

Signature of this Proposal does not bind the Practice nor the Insurers to complete the Insurance.
This Malpractice and General Liability insurance policy will be issued on a Claims Made Basis. The cover applicable at the time of a circumstance or a claim being reported will be the cover applicable at that time, subject to the retroactive date stated on the Schedule page of the policy documentation.

It is the intention of Insurers that any Contract of Insurance with the Proposer shall be based upon the answers and information provided in this Proposal Form and any other additional information provided by the Proposer. If a quotation is offered it will be the intention of Insurers to offer coverage only in respect of those entities named in answer to Question 1.
Completion of this form does not bind the Proposer or Insurer to complete the insurance transaction.

PARTICULARS OF PROPOSER

1. Full Name of Operators including Trading Name:

2. Have you ever engaged in a similar activity under a different name?

YES ☐ NO ☐ *If Yes, then please provide full information on a separate page*

3. Insured Organisations HPCSA Number

4. E-Mail Address:

5. Physical Address:

Postal Code:

On a separate page, please include Practice/Trading Address/es if different from the above

6. Telephone Number

7. Registration Number

8. VAT Registration Number

9. When established
   i) As currently constituted:
   ii) As initially established:

JULY 2015

B. ACTIVITIES OF PROPOSER

Please state the discipline(s) in which the Proposer is engaged

C. NAMES AND QUALIFICATION OF DIRECTORS/PARTNERS AND KEY PERSONNEL

1.

NAME	POSITION	QUALIFICATION	DATE QUALIFIED

If there is insufficient space above, then please provide full information on a separate page

2. Are you a member of any professional organisation, or registered with any self-regulating body?

YES ☐ NO ☐ *If 'YES' please state:*

a. Which

b. Period of membership/ registration

3. Has membership or registration with such organisation/body ever been suspended, withdrawn, amended or declined or had any special conditions attached?

YES ☐ NO ☐ *If yes, then please provide full information on a separate page*

4. Please give full details of what patient records are kept, where, how long they are stored, and how long they are retained for

JULY 2015

D. STAFF COMPLIMENT

1. Fully Qualified and Trained Paramedics

NUMBER OF BASIC AMBULANCE ASSISTANTS (BAA / ECA'S)	NUMBER OF AMBULANCE EMERGENCY ASSISTANTS (ILS)	NUMBER OF ADVANCED LIFE SUPPORT MEDICS (ALA)

2. Please state:

a. Number of ambulances in operation

b. Are these ambulances all fully equipped to handle any/all emergencies?

YES ☐ NO ☐ *If No, please give details on a separate page*

c. Number of crew members per ambulance per category:

1) Basic Ambulance Assistance

2) Ambulance Emergency Assistance

3) Fully trained/ qualified paramedics

d. Number of rapid response vehicles in operation:

e. The minimum qualification of rapid response vehicle crewmembers

f.

	AMBULANCES	RAPID RESPONSE VEHICLES
The approximate number of emergency calls per month		
The approximate number of routine trips to hospital / interhospital transfers per month		
The average approximated radius of operations		

JULY 2015

g. Number of shifts and hours worked per shift of crewmembers, per category:

	AMBULANCES AND RAPID RESPONSE VEHICLES	
	NO. OF SHIFTS	HOURS PER SHIFT
Basic Ambulance Assistants		
Ambulance Emergency Assistants		
Advanced Life Support Staff		

h. Is an air ambulance repatriation service maintained?

YES ☐ NO ☐ *If Yes, please state:*

The territories in which you expect to operate:

The number of repatriations per annum:

i. Does any person involved in treatment and care of any patient suffer from any disability, transmittable diseases ie. Hepatitis, HIV etc or other impediment which may affect the performance of his / her professional duties or place patients / clients at risk?

YES ☐ NO ☐ *If yes, what procedures are in place to manage the risk?*

j. Has the proposer or any employee involved in the treatment or care of patients been the subject of or convicted of any criminal offence (other than minor traffic offences), professional disciplinary proceedings or inquiries?

YES ☐ NO ☐ *If yes, what procedures are in place to manage the risk?*

E. FINANCIAL INFORMATION

1. When was your immediate past Financial Year End: ______

2. Please state:
   What was the past years total gross annual income excluding income from the sale of goods?

   R ______

   What is your estimated years total gross annual income excluding income from the sale of goods?

   R ______

F. CLAIMS EXPERIENCE

1. Have any claims ever been made against the proposed Insured/Partners/Directors/Members or Employees for the type of cover for which you are now applying?

   YES ☐ NO ☐

   If yes, please provide full details of all claims or incidents during the last 10 years on a separate page. Kindly include Date Of Incident, Date Of Claim, Amount Claimed, Amount Paid, Amount Outstanding, Details including nature of the allegations and the details of the claimant.

   If NONE, please state None ______

2. Are any of the Proposed Insured/Partners/Directors/Members or Employees, after enquiry, aware of any circumstances which would be covered under a policy of this type that may result in any claims or a possible claim being made against them?

   YES ☐ NO ☐

   If yes, please provide full details on a separate page. Kindly include Date Of Incident, Anticipated Claim Amount (if possible), full details and contact details of employees involved, nature of the allegations, and details of the claimant.

   If NONE, please state None ______

G. INSURANCE HISTORY

1. Are you in the present of have you in the past been Insured?

   YES ☐ NO ☐

   If Yes, please state:

   a. Insurers ______

   b. Limit of Indemnity **R** ______

   c. Excess (Each and Every Claim) **R** ______

JULY 2015

d. Premium R

e. Date of expiry of coverage

f. Retroactive Date

2. For the type of Insurance now being proposed, has any Insurer ever:

a. Declined Proposal or renewal? YES NO

b. Required an increased premium or imposed special terms? YES NO

c. Cancelled the Insurance? YES NO

If any answer is Yes to any of the above 3 questions, please provide full details on separate page

3 a) Have all the above in question F been notified to your previous Underwriters? YES NO

b) Have all of the above in F been accepted by your previous Underwriters? YES NO

H. REQUIRED COVER

Please tick the box for the Limit Required for the Operator / Insured Entity

LIMIT FOR OPERATOR	R10,000,000.00	R15,000,000.00	R20,000,000.00	R25,000,000.00

I. ADDITIONAL INFORMATION

YES NO

Is there any further information that should be made known to the Underwriters in order that they may form a proper estimate of the risk?

If yes, please attach relevant brochures or publications, copies of contract conditions or advise on a separate page.

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DECLARATION

We declare that the statements and particulars in this Proposal Form are true to the best of our knowledge and belief and that we have not misstated, suppressed or omitted any material facts.

We agree that this Proposal Form together with any other information supplied by us shall form the basis of any contract of Insurance effected thereon and shall be incorporated therein.

We undertake to inform Insurers of any material alteration of these facts whether occurring before or after completion of the contract of Insurance.

Signing this Proposal Form does not bind the Proposer to complete this Insurance.

We acknowledge that if this proposal is accepted, the contract of insurance will be subject to the terms and conditions as set out in the policy wording as issued or as otherwise specifically varied in writing by Hollard.

DATED THIS ______ DAY OF ______ 20 ______

FOR AND ON BEHALF OF: ______

SIGNED BY:

______

CAPACITY AT COMPANY:

______

PLEASE NOTE:
This Proposal Form should be completed by YOU and signed by YOU. If the Proposal Form has been completed by your BROKER, review the Proposal Form before signing it. DO NOT sign a BLANK Proposal Form.

JULY 2015