Aon SA Medical Malpractice Application Form for EPASSA Members

Claims Made:

All medical malpractice & professional indemnity policies are underwritten on a “Claims made” basis. This means that:

1. In order for a claim to qualify for indemnity a policy must be in force when the claim is first made against the insured. (In terms of the policy conditions you are obliged to notify insurers as soon as you become aware of any circumstances which may lead to a claim. Any actual claim which then materialises would be deemed to be a claim made under the policy which was in force at the time when the circumstance was first notified).
2. The cause of action giving rise to the claim must have taken place on or after the ‘retroactive date’ shown on the certificate of insurance.
3. If the policy has lapsed there will be no cover notwithstanding the fact that the policy may have been in force at the time when the cause of action arose giving rise to the claim. It is therefore important to renew the policy annually in this regard.

Retroactive Date:

Claims first made against the insured arising from work performed on or after the retroactive date as it appears on the schedule of insurance will be indemnified in terms of the policy. This date is normally fixed as being the date on which the cover was first taken and would remain unaltered for the purposes of subsequent renewals. When cover is first taken, additional retroactive cover may be offered by insurers subject to certain conditions and premium loadings. Should you be uncertain about whether or not you require retroactive cover, please contact us so that we can assist you.

Vicarious Liability

In South African law, employers are vicariously liable for the negligent actions and omissions of their employees committed in the course and scope of their employment.

Non – Cancellable Annual Policy

The policy is an annual non-cancellable policy and will run for a period of 12 months from inception/ renewal.

PERSONAL INFORMATION

1. Full Name		
2. Title	3. Gender	
4. ID Number / Passport Number		
5. Incorporation details (if any)		
6. Trading name (if different from the above)		
7. Please provide your VAT registration number		
8. How long have you been in practice?		
9. Practice Address		
10. Postal Address		
11. E-mail	Telephone / Mobile Number	Website if applicable

YOUR PROFESSIONAL SCOPE

12. HPCSA / AHPCSA / SACSSP / SANC / Other Registration Number		
13. Practice Number if Applicable		
14. Qualifications / Including any Additional Training / Fellowships		
Degree	**Year Obtained**	**University**

15. Are you a member of any professional organisation or registered with any self-regulating body?	Yes	No

Body	**Registration Number**	**Type**	**Date Of Registration**

YOUR PRACTICE

16. Please indicate which of the following you practice			
A sole Practice	A Partnership	An Employee	Locum
State Employed (please specify If permanently employed or sessional)		Other	

17. Please confirm the constitution of your practice from the following:			
Sole Proprietor		Partnership	
Incorporation		(Pty) Ltd	
Other, please specify			
18. Please indicate the number of annual consultations:			
Only Private		Only State	
Both State and private patients. (total must equal 100% of your work)		% of Private Patients	% of State Patients
19. Please indicate name of hospital(s) and/ or practice where you treat patients			
Name of Hospital / Practice	Address		
20. Do your partners carry their own malpractice insurance? If so, state with whom and provide the number of partners			
21. Total number of employees and scope of practice; for example, 1 nurse, 1 receptionist			
22. Total number of independent contractors working in the practice and their scope of practice; for example 1 locum doctor			
23. Is it mandatory that all your patients sign consent for: a. Consultations b. Surgical Procedures and/or theatre procedures/operations		Yes	No
24. What is the current system you capture patient notes?			
Manual	Electronic	Other:	
25. Do you comply with the provisions of the Protection of Personal Information Act (POPIA) regarding the safeguarding of patient/customer information?		Yes	No
26. Are accurate and descriptive records of all medical services and procedures kept?		Yes	No
27. How are your patient records secured?			
28. How long do you retain patients' medical records?			
29. Do you comply with regulatory guidelines on the keeping of patient records?	Yes	No	Unsure

30. Income

Gross Revenue	**Last Financial Year**	**Previous Financial Year**	**Estimated forthcoming 12 months**
Gross revenue from private practice			
Gross revenue from state institutions			

31. Please describe all your activities

32. Scope of practice (area of specialisation, including any sub-specialty)

33. Additional Procedures

	Yes	No	In Private Practice	State / Government
Do you conduct and/or participate in clinical trials?				
If yes : **Description of the type of clinical trial and drug used & a copy of your workload (services provided) for the trial.**				
Telehealth (If yes refer to Addendum A)				
Other:				

34. Insurance History

Have you or are you presently Insured in respect of Medical Malpractice	Yes	No
If Yes, please provide the following information		
Name of Insurers:		
Limit of Indemnity:		
Annual Premium		

35. Confidential Professional Information / Claims

a.	Have any circumstances/incidents/complaints/ claims of professional negligence, error or omission been made against the entity or any of the present or past Principals, whether insured or not, in the past 5 years? *If YES, please provide full details on a separate page including Date of claim /Total value claimed, total value paid (if paid) / Description / Nature of allegations*	Yes	No
b.	Have you or your partners ever been investigated, or are currently under investigation by the HPCSA / relevant professional regulatory body overseas / medical scheme? *If YES, please provide full details on a separate page*	Yes	No
c.	Have you ever been the subject of an inquiry by your employer, a non-regulatory professional body and/or a third party like a hospital or medical scheme? *If YES, please provide full details on a separate page*	Yes	No
d.	Have you ever had conditions imposed on your practice, been suspended or removed from the medical register due to a complaint, inquiry or investigation? *If YES, please provide full details on a separate page*	Yes	No
e.	Has a criminal claim of any nature ever been made against you / your partners/ your entity? If YES, please provide full on a separate page	Yes	No
f.	Have you or your partners had any civil or criminal actions against you, where there was a finding of liability or guilt with respect to your clinical practice? *If YES, please provide full details on a separate page*	Yes	No
g.	Has any application for insurance of this nature ever been declined, cancelled or has renewal been refused or have special terms been imposed ? *If YES, please provide full details on a separate page*	Yes	No
h.	Have you ever had any hospital privileges restricted or suspended, whether voluntarily or involuntarily? *If YES, please provide full details on a separate page*	Yes	No
i.	Has your professional status or professional role/job changed in the past 12 months? *If YES, please provide full details on a separate page*	Yes	No
j.	Do you have any physical or mental condition or substance abuse problems that could affect your ability to safely and competently undertake the provision of care? *If YES, please provide full details on a separate page*	Yes	No
k.	Is there any additional information that may have significance when we assess your individual risk?		

36. OPTIONAL ADDITIONAL COVERAGE OFFERING (Please indicate if you wish to have this cover included):

NEEDLESTICK COVER		
Plan 1	**Benefit**	
Accidental Death	R 70 000	
Permanent Total Disability	R 100 000	
Occupational HIV - Preventative Medical Treatment	Actual incurred up to R 10 000	
Occupational HIV – Capital Lumps sum benefit upon zero-conversion	R 25 000	
Annual Premium Per Individual	**R 225.00**	
Plan 2	**Benefit**	
Accidental Death	R 35 000	
Permanent Total Disability	R 50 000	
Occupational HIV - Preventative Medical Treatment	Actual incurred up to R 10 000	
Occupational HIV – Capital Lumps sum benefit upon zero-conversion	R 12 500	
Annual Premium Per Individual	**R 120.00**	
a. Can we include Needlestick Coverage?	Yes	No
b. If Yes, please confirm which Plan?	Plan 1	Plan 2

ADDENDUM A:

PLEASE READ BEFORE COMPLETING THIS SECTION

Please answer ALL questions completely.
Should any question or part thereof not be applicable, please state “N/A”.
Should insufficient space be provided, please continue your company letterhead.

If you provide services to international clients or online therapy, please respond to the questions raised below which need to be referred to the Insurer.

1. Do you do undertake online therapy/counselling?						Yes	No
If yes, please select the indicative percentage below:							
Less than 15%		15% - 25%		25% - 50%		More than 50%	
2. Do you undertake online international work? If yes what percentage?						Yes	No
Less than 15%		15% - 25%		25% - 50%		More than 50%	
Which countries?							
Is your client domiciled in the abovementioned country/ countries?							
3. Do you declare and appropriately limit the nature and extent of your finding – given therapy is done online?						Yes	No
4. What means of online platforms are used?							
5. Are sessions provided in English only?						Yes	No
What processes are instituted if there is a language barrier?							
6. Do you provide your patient with information pertaining to the consultation, including information about the nature and objectives of the services concerned?						Yes	No
7. Do you obtain informed consent to record electronically or to transmit information electronically and do you inform the client of the risk of breach of privacy or confidentiality inherent in the electronic recording or transmission of information?						Yes	No
8. How is consent obtained?							
9. Copy of consent forms to be provided – Please attach							
10. Do you provide any written reports to a consulting Practitioner in the country of the patient?						Yes	No
11. Do you work independently or via an international Organisation – if the latter we will need what controls of supervision etc. are in place.						Yes	No
12. Do you comply with the guidelines as set out by the HPCSA in respect of General Ethical Guidelines for Good Practice in Telemedicine?						Yes	No

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Have you read and understood the explanation above regarding a claims made basis policy?_____

OTHER AON SERVICES:

a. **Commercial Insurance**: Can Aon commercial insurance division contact you to provide a quote for your commercial insurance?	Yes	No
b. **Personal Insurance**: Can Aon contact you with regards to a group scheme or personal lines policy quote?	Yes	No
c. **Directors & Officers Liability**: In terms of the provisions of the new Companies Act the duties and responsibilities of directors & officers are very onerous. The Directors & Officers Liability insurance covers actions brought against the directors and prescribed officers alleging a negligent or wrongful act. This can be on a named or blanket basis and applies to past, present and future directors and officers of the company and its subsidiaries. Can Aon contact you with regard to a Directors & Officers Liability Policy?	Yes	No
d. **Cyber liability** is a specialty insurance product intended to protect businesses from Internet-based risks, and more generally from risks relating to information technology infrastructure and activities	Yes	No

Privacy Clause

To provide you with insurance, we have to process your personal information. We will share your personal information with other insurers, industry bodies, credit agencies and service providers. This includes information about your insurance, claims and premium payments. We do this to provide insurance services, prevent fraud, assess claims and conduct surveys. We will treat your personal information with caution and have put reasonable security measures in place to protect it. By signing this insurance application, you agree to the processing and sharing of your personal information.

Declaration which must be signed by the proposer only

Important – It is necessary for you to inform us of all the facts that are likely to influence us in the acceptance or assessment of your indemnity. Failure to do so could invalidate this indemnity. If you are in doubt whether any fact may influence us, you should disclose it.
I declare that to the best of my knowledge or belief, the statements and particulars given in this proposal are true and complete and that no material facts that are likely to influence the acceptance and assessment of this proposal have been withheld (if you are in any doubt whether a fact is material, you should disclose it).
I agree to inform the Insurer of any change to any material fact. I also declare that if any information on this proposal has been written by another person on my behalf, that that person acted as my agent for that purpose. I agree that this proposal and declaration shall be the basis of the contract between myself and the Insurance Company that will accept the risk.

Name of Proposer [print]:	
Signature of the Proposer:	
Date:	