SPECIALIZED
INSURANCE COMPANY

PROPOSAL FORM

MEDICAL PRACTITIONERS

1. Policy Holder Details

Title			
First Names			
Surname		Date of Birth	
Identity Number			
Practice Number			
Incorporation Details			
Medical Practitioner ("MP") Registration Number			

2. Contact Details

Practice Phone Number/s	
Mobile Number	
Home Telephone Number	
Fax Number	
E-mail Address (Practice)	
Website	
Practice Address (Main)	
Postal Address (Main)	

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2. Practice Details

2.1.	Previous malpractice cover details: Name of institutions and number of years of membership with each			
a)	Institution Name		Membership (Number of years)	
b)	Institution Name		Membership (Number of years)	
c)	Institution Name		Membership (Number of years)	

2.2.	Are you in private practice, government employed (no private work) or government employed (with private work)?

2.3.	If you are in private practice please confirm if you are a sole practitioner, in partnership, in association or practicing

2.4.	Year qualified as medical doctor (primary medical qualification)	

2.5.	Registered qualifications, dates and institutions at which they were obtained

Qualification	Institution	Date Obtained

2.6.	Scope of Practice (discipline and area of specialization, including any sub-specialty details)

2.7.	Do you perform any surgery?	Yes		No	

If yes, please specify the surgical procedures you perform the most and the percentage (%) proportions

2. Practice Details (Cont.)

2.7.	Has any claim or complaint ever been made against you or your practice, including those notified to any other insurer or society?	Yes		No	

If yes, please confirm the type of incident, year, patient name and outcome

2.8.	Have you ever been the subject of any disciplinary proceedings by the HPCSA, criminal prosecutions or inquest proceedings?	Yes		No	

If yes, please confirm the type of incident, year, patient name and outcome

2.9.	Are you aware, after due consideration, of any claims or complaints that may be made against you or your practice?	Yes		No	

If yes, please confirm the type of incident, year, patient name and outcome

2.10.	Is there any other information which you consider material to the risks to be insured that should be disclosed?

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3. Practice Statistics

Annual Total	Number of Consultations	Number of Proceedures	Annual Growth Taxable Turnover (inc. VAT)
Private Practice Totals			
Government Practice Totals			

4. Obstetrics & Gynaecology Statistics (If any)

Annual Total	Caesarean Sections	NVD's	Hysterectomies
Private Practice Totals			
Government Practice Totals			

5. Comments and Choice of Indemnity Limit

5.1.	Choice of indemnity limit		Inception Date	

5.2.	General or risk comments or requests

6. BANK DETAILS FOR DEBIT ORDER

Branch Name		**Branch code**	
Account number		**Account type**	
Payment frequency			
Signature as authorisation to perform certain administrative and legal functions, and for debit order deductions:			

DECLARATION

I declare that the information in this proposal is true and correct and that I have disclosed all facts material to the underwriting of the risks to be insured. I agree that the information contained in this proposal for insurance shall form the basis of the contract of insurance.

Name		Date	

Signature	