Professional Indemnity PIFRS PI Financial Risk Services *Financial Risk Services*

PHARMACY PROFESSIONAL INDEMNITY INSURANCE RENEWAL FORM

NAME OF PHARMACY: (Please complete the following) **VAT Number:** _____

PHARMACY / HOLDING COMPANY NAME: _____

NAME OF PHARMACY (if different to above)_____

CURRENT POLICY NUMBER: _____ Phone No: _____email: _____

ADDRESS: _____

ANNUAL TURNOVER: (Please Give your turnover for the previous business year): R_____

(Your Estimated Turnover for the forthcoming year): R_____

No Claims DECLARATION:

Have you been sued by a patient or received a lawyers letter/summons from a patient in the last year? : YES NO

Have you had a disciplinary enquiry or any complaints laid against you at council in the last year? : YES NO

Are you aware of any incident, no matter how small, that may result in a patient taking action against you, your pharmacy or any staff member or locum in the last year? : YES NO

If yes to any of the above, please provide brief details in an email and attach this renewal.

6. **LEVEL OF COVER REQUIRED: (If you want more cover than last year, circle one of the below boxes)**

CIRCLE REQUIRED AMOUNT FOR PI/Medmal only	**R5,000,000.00**	**R10,000,000.00**	**R20,000,000.00**
CIRCLE REQUIRED AMOUNT FOR PI Medmal / Product Liability/Pollution Liabiltiy and Broadform Liability	**R5,000,000.00**	**R10,000,000.00**	**R20,000,000.00**

7. **DECLARATION:**

I/We declare and warrant that there have been no material changes to the pharmacy/business since completing the Proposal form last year and that no information whatever has been withheld which may increase the risk of the Underwriters or influence the acceptance of this RENEWAL Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as possible. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the proposal may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this declaration shall be the basis of the contract between both parties if entered into.

Full Name of Proposer: (you the pharmacist/owner)

SIGNATURE: **DATE:**

PLEASE SCAN AND EMAIL BACK TO CHARLES SKINNER, PIFRS: charless@pifrs.co.za or phone: 082 338 3950