PIFRS
PI Financial Risk Services

firstEquity
Risk Management Services (Pty) Limited
Advisory and Broking Services

HOSPITALS, CLINICS, NURSING HOMES AND THE LIKE, MEDICAL MALPRACTICE LIABILITY INSURANCE PROPOSAL FORM

NB: Kindly ensure that all questions are answered as required. Kindly also ensure that the Declaration is signed and dated accordingly.

CLAIMS MADE

Annual renewable 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 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 in the Schedule of the policy.

RETROACTIVE COVER

The date on or after which any claim made against the Insured 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.

NON-CANCELLABLE ANNUAL POLICY

The policy is an annual policy and does not contain a bilateral cancellation condition

Full name of the Institution (hereinafter referred to as the "Institution")	
Address or Addresses of the Premises	

Please state the Owner(s) and/or Partner(s) names and details of their experience and qualifications.

Name & Address	% Shareholding	Experience/Qualifications

To assist Insurers in assessing whether there is any possibility of action(s) being brought against them under the jurisdiction of American Courts, please disclose whether or not any of the above shares are held by U.S. Interests. (This will affect the availability of cover).

How long has the Institution been managed by the present Owner(s) / Partner(s)	
Are Public Funds or Private Funds or Endowments used to maintain the Institution, either in whole or in part?	Yes No
If so, please state percentages.	
Are any of the beds of the Institution or any of its services available to the community on a CHARITABLE basis?	Yes No
Please disclose estimated gross Annual Income and state whether Fees or Gross Revenue.	
Has the Institution been issued with the necessary licence by the Local Authority, enabling it to trade legally at the premises specified above?	Yes No

If not, please advise submission date.	
Please can you provide your VAT Registration Number?	
Please can you provide your company registration number?	

Is the Institution	a member of a group of hospitals		Yes No
	affiliated to any other medical interest		Yes No
	(If yes, details)		

Please give brief description of the Institution's activities.							
Surgical	%	Medical	%	Orthopaedics	%	Obstetrics	%
Gynaecology	%	Paediatric	%	Ophthalmology	%	E.N.T	%
Drug Addiction	%	Alcoholics	%	Communicable	%	Tubercular	%
Senile / Aged	%	Insane	%				
Any other classes?							

Please state number of beds maintained:	Full pay beds or part-pay beds (other than bassinets for maternity cases)	
	Charity beds (other than bassinets)	
	Maternity beds (i.e. bassinets)	
Please state average annual bed occupancy (Average bed occupancy may easily be calculated by noting the occupancy at the end of (or any specific day of) each month and dividing the aggregate total of 12 months' figures by 12).		

Please state number of X-Ray machines owned or operated, and whether they are used for:-	Diagnosis - No.		(by whom is treatment given)
	Treatment - No.		

Does the Institution give Radium, or any other forms of radio-active treatment?		Yes No
If so, please give details.		

Please state the number of employees in each of the following classifications.				
MEDICAL STAFF	Surgeons specialising in		Doctors of Medicine specialising in	
	Radiologists		Radiographers	
	Laboratory Technicians		Pharmacists	
Qualification(s) & Year(s) obtained				
Name of Director of Nursing				

NURSING STAFF	S.R.N'S	Day		Night	
	S.E.N'S	Day		Night	
	Auxilary Nurses	Day		Night	
	Student Nurses	Day		Night	

Does the Institution undertake the training of staff?		Yes No
If so, please give details.		
Does the Institution undertake to ensure that all trainees carry out their duties under proper supervision?		Yes No
Does the Institution maintain Clinics?		Yes No

If so, please state:-	Type(s)			
	Whether free to patients		Full-pay	
			Part-pay	
	The number of Clinics		Doctors	
			Nurses	
Estimated total number of patients per year				

Please advise	The type of construction of the premises?	
	The number of storeys?	
	The number of rooms occupied by patients?	
	The type of floor (concrete/wood)?	
	The age of the structure?	
	Whether purpose built?	
	If not purpose built, please state date of conversion?	

Please state:-	The distance to the nearest Fire Station		
	What hydrants, extinguishers, sprinklers, direct plant links to the Fire Brigade etc., are installed?		
	The construction and conditions of fire escapes		
	Are your staff instructed in Fire protection procedures?		Yes No

Does your staff receive any medical malpractice risk management training?	Yes No
Are you at present or have you in the past been insured?	Yes No

If so, please give details.	
What Public Liability Insurance coverage does the Institution have?	

Has any Insurer, either Company or Lloyd's Underwriters ever cancelled, declined, refused to renew or only accepted on special terms the Institution's Malpractice Insurance?	Yes No

If so, please give details.	

Have any claims been made against the proposed Insured Partners, Directors or Employees which will be covered under a policy for which you are now applying e.g. Professional Negligence?	Yes No

If so, please give details.	

In deciding which Limit of Indemnity to select, consideration should be given to factors affecting your risk profile. These factors include: - the nature and complexity of work undertaken; contractually agreed limitations of liability (if any) and the requirements of your patients. Should you be uncertain as to what would be an appropriate level of cover to select in your circumstances, please contact us so that we can assist you.
Is there any further information that should be made known to the Company in order that they may form a proper estimate of the risk? (Please attach any relevant publications or brochures)

Do you require retro-active cover?	Yes No

DECLARATION

I/We hereby declare that the above statements and particulars are true and complete, that at the present time, other than as stated above, I/We have no reason to anticipate any claim being brought against me/us that would constitute a claim under the insurance now being requested. I/We agree that this proposal and declaration shall be the basis of the contract between me/us and the Insurers.

________________ ________________________________

Date: Signature of Proposer

Kindly email proposal form to info@pifrs.co.za or fax to (011) 706 4959.