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

INDIVIDUAL PHARMACIST/PHARMACY CLINIC SISTER PROFESSIONAL INDEMNITY INSURANCE PROPOSAL FORM

1. PERSONAL DETAILS: (Please complete the following)

Surname: _____ TITLE: _____

Full first names:_____

ID No: _____ SAPC/Nursing Council No: _____

(Voluntary Information): Are you (or were) a member of any voluntary Association/Organsisation/Society ?: YES NO

Name of Ass/Org/Society: _____ Membership Number if you have it: _____

Address: POSTAL:_____

_____CODE:_____

PHYSICAL:_____

_____CODE:_____

EMAIL ADDRESS: _____ CELL PHONE: _____

WORK PHONE: _____ HOME: _____

2. PROFESSIONAL DETAILS:

PLEASE LIST YOUR QUALIFICATIONS, UNIVERSITY/COLLEGE ATTENDED AND YEAR OBTAINED:

DEGREE/dipl 1: _____ _UNIV/COLLEGE: _____ YEAR: _____

DEGREE/dipl 2: _____UNIV/COLLEGE: _____ YEAR:_____

3. PREVIOUS INSURANCE AND CLAIMS DETAILS (Disclosure):

Are you currently covered for malpractice insurance by an insurance company or friendly society?: YES NO

If YES, name of current insurer: _____ Policy/Certificate Number: _____

(If you can, attach a copy of the policy / certificate for us to give a retroactive date as per that policy)

(Circle either yes or no)

Have you ever been refused Professional Indemnity cover or had the insurance company cancel?: YES NO

Have you had a disciplinary enquiry or any complaints laid against you at council: YES NO

Have you been sued by a patient before or received a lawyers letter from a patient: YES NO

If so, have you notified or has your previous/current insurer been notified?: YES NO
(Please supply a brief summary on a separate sheet)

Are you aware of a recent incident that may lead to a patient complaining to council or suing you? YES NO

4. DECLARATION:

PIFRS/Leppard claims made policy covers claims or suits arising from the provision of/or failure to provide professional healthcare services after the retroactive date on the policy and first brought to your attention while the policy is in force.

Run-off cover can be provided for up to 3 years post 'ceasing to practice' or 'retirement' on cancellation of this policy subject to having been insured for a minimum of 3 years subject to notification of any potential claims or declaration thereof or not being aware of any potential claims. This is at no cost to you - if this policy has been taken up for more than 3 years. If you have had the policy for less than 3 years, this run-off cover is subject to underwriters approval and may in certain instances cost up to 1 years premium.

I/We declare and warrant that after enquiry all statements and particulars contained in this proposal and any attachments or addenda are true and that no information whatever has been withheld which may increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/We will advise the Underwriters as soon as possible. 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:

SIGNATURE : **DATE:**

SIGNING OF THIS PROPOSAL FORM DOES NOT BIND THE PROPOSER OR UNDERWRITERS TO COMPLETE A CONTRACT OF INSURANCE.

PLEASE GO TO THE NEXT PAGE, THIS TABLE OVERLEAF IS THE RATE TABLE AND WILL BE THE GUIDELINE USED TO RATE YOU ONCE WE HAVE THE COMPLETED, SIGNED AND DATED FORM RETURNED. (It is unlikely you will be quoted anything else, but it is possible subject to this declaration form).

Overleaf just circle the area of work you fall into, circle the premium option under the sum insured you request. If you choose to pay annually, we will invoice you and provide a banking account for EFT. If monthly complete banking details overleaf.

SCAN AND EMAIL OR FAX TO: Charles Skinner: charless@pifrs.co.za

FAX Number: 011 706 4959

(Phone 082 338 3950 for any assistance)

CIRCLE THE MONTH YOU WANT TO START:

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

JUST circle the amount of cover and the category you fall into & circle the annual premium (or the monthly premium if you wish to pay monthly). (LOI means limit of indemnity or how much you want to be insured for)

INDIVIDUAL PHARMACIST/ PNP / PHARMACY CLINIC NURSE RATES

	LOI R5million in agg	LOI R10million in agg	LOI R20million in agg
Managing Directors (Industry), Research Pharmacists			
Clinical Trials, Responsible Pharmacists in Industry	R2,090.00 annually	R2,680.00 annually	R3,800.00 annually
Senior Pharmacists in Industry (Management)	or	or	or
PCDT or Prescribing Pharmacists	(R190.00 monthly)	(R242.00 monthly)	(R340.00 monthly)
Retail / Private Sector Responsible Pharmacists	R1,800.00 annually	R2,300 annually	R3,200.00 annually
	(R167.00 monthly)	(R214.00 monthly)	(R295.00 monthly)
Retail Pharmacy, **Locums** (all locums in pvt sector),			
Industrial Pharmacists (Middle management)	R1,280.00 annually	R1,590.00 annually	R1,980.00 annually
Responsible Pharmacists working for Govt/State			
Pharmacy Clinic Nurses, Woundcare Nurses	(R115.00 Monthly)	(R146 monthly)	(R182.00 monthly)
Govt employed Pharmacists doing private locums			
Govt employed Pharmacists (ie work only for state)	R980.00 annually	R1,280.00 annually	R1,720.00 annually
Regulatory Affairs Pharmacists (not doing locums)	(R93.00 monthly)	(R115.00 monthly)	(R159.00)
Pharmacy Technicians	R620.00 annually	R830.00 annually	
	(58.00 monthly)	(R76.00 monthly)	
Interns, Comm Service Pharm, Academic Pharm	R450,00 annually	R580.00 annually	
Pharmacy assistants both basic and post basic			
(IF ASSISTANTS FULL TIME GOVERNMENT employed)	**(R365 annually)**	**(R495 annually)**	
Pharmacy Students / Pharmacy Technician Students	R130,00 annually		

First Amount Payable each and every claim: R2,000.00

Broker: PIFRS (FSP No. 48354) **Any Questions?:** Phone Charles Skinner: **082 338 3950** (24/7)

Underwriter: Leppard and Associates (Pty) Ltd (FSP No. 274) **Insurer:** Lombard Insurance Company Ltd (FSP No. 1596)

Please note: The above rates include VAT: (20% commission for PIFRS and a R50.00 policy fee for PIFRS all included in the above rates.)

IF YOU OPT TO PAY MONTHLY, PLEASE COMPLETE BANKING DETAILS: (Only applies where monthly option available above).

Account Holder: _____ Bank: _____

Branch : _____ Branch Code: _____

Account Number: _____

Monthly: Please Circle: (Cheque) (Savings) (Transmission) OR: Annually: (Invoice Me)

No certificate can be issued without Proof of Payment. (Please - wait for invoice if paying annually)

SIGNATURE: _____