

Medical Malpractice Application Form

This is an application for Medical Malpractice Insurance which is provided on a 'claims made' basis – for more information, please visit our website - www.cover4profs.co.za

Please Note: SASOHN membership is a condition of cover and therefore no cover will be afforded to you should you not renew your membership.

It is important that you disclose to the Insurer all information which is material/relevant in order for them to decide whether to issue insurance cover to you. This includes any facts or conduct which might lead to a claim or regulatory complaint being made against you. Failing to do so could affect your rights to indemnity.

You will be bound by the answers, which are given, and by the information provided by you in this proposal form. It is in your interest to make sure that all information is correct and properly understood. If in doubt, it is always better to disclose as much information as possible.

The policy will only respond to claims and/or circumstances, which are first made against the Insured and notified to the Insurer, in writing and through CFP Brokers (Pty) Ltd) during the policy period. The policy will **not** provide cover for:

- Events that occurred prior to the retroactive date of the policy.
- Claims made or notified after the expiry of the policy period
- Claims notified or arising out of facts or circumstances notified under any previous policy
- Claims arising out of services rendered in the USA or Canada or any territory which is subject to their laws.
- Any claim if you have not paid the premium for the policy period

By completing this document, you are allowing CFP Brokers (Pty) Ltd to process your personal information and issue you with an invoice for cover. **Filling in the form does NOT guarantee cover**, and only upon the issuing of an invoice and the payment of that invoice with the correct Reference number will cover be in place – you will receive an email confirming cover. **No email = No cover**

Forms with missing information will NOT be processed – please ensure that all information is completed and that your answers are written clearly

Profile Information Required:

| | |
|---|---------------------------|
| First Name(s) | |
| Surname | |
| Title/Salutation | |
| RSA Identity Number/Passport number | |
| Email Address | |
| Mobile Number | |
| Address | |
| Last University Attended | |
| Qualification/Degrees | |
| Association/Society that you belong to | SASOHN |
| Profession | Occupational Health Nurse |
| Primary Professional Activities | |
| SASOHN Membership Number | |
| SANC number | |

In completing the application form, you are applying for the cover as details below:

| Who can take up this cover | What is covered | Limit of indemnity | Annual Premium |
|--|--|--------------------|----------------|
| All paid-up fully qualified subscribing who hold full membership in respect of occupational health nurses & SASOHN Life Members and those who have been awarded honorary Life membership subject to there having been fully paid-up members prior to being awarded Life membership, SASOHN employees, committee members, office bearers, volunteers, officials, peer review panellists and Society-appointed Ombudsman and SASOHN itself | <ul style="list-style-type: none"> Medical malpractice, professional indemnity and defence costs. Public and products' liability included. Cover for vicarious liability included. All extensions of cover included. | R5,000,000 | R450.00 |

The below table MUST be completed in FULL - What was/is your **annual salary**?

| | In 2021 | In 2022 | Estimate for 2023 |
|--------------------------------|---------|---------|-------------------|
| From private practice | | | |
| From state institutions | | | |

Please **CIRCLE** the answer that is **applicable**:

| | | | |
|--|--|-----|----|
| Past Claims Declaration | Have any claims of professional negligence, HPCSA/SANC complaints, regulatory or disciplinary inquiry's ever been made or threatened against you ? | YES | NO |
| Future Claims Declaration | Are you or any of your colleague's aware of a circumstance that could lead to a claim being made against you ? | YES | NO |
| Regulatory Body Declaration | Are you aware of any complaints that could be made against you at SANC or another regulatory body? | YES | NO |
| Previously Declined | Have you ever applied for medical malpractice insurance where you have not been allowed to take it up? | YES | NO |
| Declaration Residence | You are living and practicing within South Africa | YES | NO |
| Declaration | I declare that the statements and particulars given in this application are true and that I have not mis-stated or suppressed any material fact. I agree that this application, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon. I declare that I have read and understood the Definitions of commonly used insurance terms. | YES | NO |
| Information Sharing Declaration | In order to provide you with medical malpractice insurance, we have to process your personal information. We will share your personal information with other insurers, underwriters, underwriting managers and service providers such as your Association/Society/Administrator. This includes personal information about your insurance, claims and premium payments. We will treat your personal information with caution and have put reasonable security measures in place to protect it. Applying for cover on our MMSOnline system, you agree to the processing and sharing of your personal information. | YES | NO |

Full name : _____

Date: _____

Signature : _____

Once completed, please email this form to info@cfpbrokers.co.za