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Professional Indemnity Insurance Proposal Form – Private Hospitals

IMPORTANT NOTICES

Commercial & General Insurance Brokers (Aust) Pty Ltd (CGIB) is a licensed General Insurance Broker Your application will be forwarded to our Insurer panel requesting them to provide a quote. We will confirm the outcome to you on receipt of their quotations. You may be requested to provide further information. Please feel free to contact us if you would like further details.

COMPLETING THIS FORM

1. Answer all questions. Blanks &/or dashes, or answers 'known to underwriters or brokers' or 'N/A' are not acceptable & will delay consideration of this proposal form;
2. If there is insufficient room to complete a question, please attach a signed & dated addendum;
3. Any documents attached to the proposal form are part of the proposal;
4. Where appropriate, please tick the "Yes" or no box that best indicates your reply.

STATUTORY NOTICES

In this form You, Your, or Yours refers to question one (1) and We, Us or Our refers to the insurer who accepts this form.

DEFINITIONS

Insurers: Any insurer from our panel of insurers.

Insurance Provider: The Insurer from our panel of Insurers whose offer for Insurance has been accepted by the applicant.

RETROACTIVE LIABILITY

The retroactive date is the date after which any errors or omissions of the Insured are covered. Any errors or omissions made before the retroactive date are excluded by the policy. The retroactive date may be the time that the Insured first purchased a Professional Indemnity or Directors' & Officers' Liability policy. It is important to make sure that the retroactive date is correct. Remember, that the actual event that causes a claim to be made under the policy may have occurred in a prior period of insurance, but is only covered if it is notified to the Insurers in the period of insurance when the Insured first becomes aware of the claim or circumstances. The act, error or omission must arise from work done after the retroactive date shown in the schedule of the policy for the insurance to respond.

OTHER PRODUCTS & SERVICES

Please visit us at www.cgib.com.au for further information.

PRIVACY STATEMENT

We and our Insurer panel will only collect personal information from you or about you which is relevant to processing and assessing your application and use it in a way you would reasonably expect. Without this personal information we may not be able to process your application. Please see our privacy policy at: <http://www.cgib.com.au/privacy>.

Important Information Required – Please Attach

- | | | | |
|--|--------------------------|--|--------------------------|
| Copy of CV for all directors and personal providing advice | <input type="checkbox"/> | Copy of your services &/or products information brochure | <input type="checkbox"/> |
| Copy of your service contract (if applicable) | <input type="checkbox"/> | | |

Recommendations *(Please select the products that you would like further information)*

- | | | | |
|---------------------------------------|--------------------------|--------------------------------|--------------------------|
| Public & Products Liability Insurance | <input type="checkbox"/> | Management Liability Insurance | <input type="checkbox"/> |
|---------------------------------------|--------------------------|--------------------------------|--------------------------|

Medical malpractice insurance application form

You must read this notice before you complete the application form.

1. Disclosure of relevant facts

Duty of Disclosure

Under the *Insurance Contracts Act 1984* (Cth) (the Act), you have a Duty of Disclosure. You are required before you enter into, renew, vary, extend or reinstate your Policy, to tell us everything you know and that a reasonable person in the circumstances could be expected to know, is a matter that is relevant to our decision whether to insure you, and anyone else to be insured under the Policy, and if so, on what terms.

- **You do not have to tell us about any matter**
 - that diminishes the risk
 - that is of common knowledge
 - that we know or should know in the ordinary course of our business as an insurer, or
 - which we indicate we do not want to know.

- **If you do not tell us**

If you do not comply with your Duty of Disclosure we may reduce or refuse to pay a claim or cancel your Policy. If your non-disclosure is fraudulent we may treat this Policy as never having worked.

2. Claims made Policy

This declaration is for a "claims made and notified" policy of insurance. This means that the policy covers you for claims made against you and notified to the insurer during the period of cover.

This policy does not provide cover in relation to:

- claims made after the expiry of the period of cover even though the event giving rise to the claim may have occurred during the period of cover;
- claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy;
- claims made, threatened or intimated against you prior to the commencement of the period of cover;
- facts or circumstances of which you first became aware prior to the period of cover, and which you knew or ought reasonably to have known had the potential to give rise to a claim under this policy;
- claims arising out of circumstances noted on the application form for the current period of cover or on any previous application form.

Where you give notice in writing to the insurer of any facts that might give rise to a claim against you as soon as reasonably practicable after you become aware of those facts but before the expiry of the period of cover, you may have rights under Section 40(3) of the *Insurance Contracts Act 1984* (Cth) (the Act), to be indemnified in respect of any claim subsequently made against you arising from those facts notwithstanding that the claim is made after the expiry of the period of cover. Any such rights arise under the legislation only. The terms of the policy and the effect of the policy is that you are not covered for claims made against you after the expiry of the period of cover.

3. Average provision

The policy may provide that if a payment in excess of the limit of indemnity available under the policy has to be made to dispose of a claim, the insurer's liability for costs and expenses incurred with its consent shall be such proportion thereof as the amount of indemnity available under this policy bears to the amount paid to dispose of the claim.

You should familiarise yourself with our standard form of policy for this type of cover before submitting this declaration.

4. Privacy statement

QBE includes information about how we manage your personal information in our Product Disclosure Statements and policy booklets. You can obtain a copy of the QBE Privacy Policy Statement from our website www.qbe.com or contact in writing, to The Compliance Manager, QBE Insurance (Australia) Limited, GPO Box 82 Sydney NSW 2001 or email: compliance.manager@qbe.com.

Medical malpractice insurance application form

IMPORTANT: Please answer ALL questions fully. If there is insufficient space please provide details on your letterhead. Where provided, tick (✓) appropriate box to indicate answer.

A. Your details

1. Full name of the private hospital.

2. Full name of the owner.

3. Principal address of the private hospital.

	Website	
	State	Postcode

4. Address(es) of branch offices or other locations.

	State	Postcode
	State	Postcode
	State	Postcode

5. How long has the private hospital been operated by the present owners?

6. Please provide the following details:

Title of staff member	Name	Age	Qualifications	Date qualified
Chief executive officer/General manager				/ /
Director of medical services				/ /
Director of allied health services				/ /
Director of nursing				/ /

7. Is the private hospital duly licensed to practice at the address(es) specified in questions 3 and 4?

 Yes No

8. Total number of employees in each of the following classifications:

(a) Surgeons		(f) Pharmacists	
(b) Doctors		(g) Registered nurses	
(c) Interns		(h) Enrolled nurses	
(d) X-ray technicians		(i) Undergraduate or student staff	
(e) Laboratory technicians		(j) Other medical or allied health employees	
Total			

B. Private hospital details

9. (a) Has the name of the private hospital ever been changed?

 Yes No

(b) Has any other private hospital amalgamated or merged with you?

 Yes No

(c) Have you purchased any other private hospital?

 Yes No

If you have answered 'Yes', to either (a), (b) or (c), please provide details:

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10. Please list the professional bodies or associations you belong to.

B. Private hospital details

11. Does the private hospital have:

- (a) an intensive care unit? Yes No
- (b) a casualty or outpatients department? Yes No
- (c) a radiotherapy unit? Yes No
- (d) a medical teaching facility? Yes No

12. Does the private hospital operate any training school?

If 'Yes', please provide details:

Yes No

13. Do you maintain accurate descriptive records of all medical services rendered?

Yes No

14. Do you ensure that all doctors of medicine (whether employed or visiting) who provide services for, or use the facilities of, the private hospital are members of a recognised medical defence union/association or protection society, or otherwise carry their own malpractice liability insurance covers?

Yes No

15. Is there a blood banking facility?

If 'Yes', please provide the following details:

Yes No

(a) (i) percentage of blood bought		%
(ii) percentage of blood collected		%
(b) (i) approximate number of litres per annum		
(ii) approximate number of plasmapheresis procedures carried out per annum		
(iii) estimated annual gross receipts from the sale of the following per annum:		
• white blood	\$	
• blood plasma	\$	
• serum	\$	
• other blood products or derivatives	\$	

(c) Please provide details of:

(i) the screening procedure of persons from whom blood or plasma is drawn.

(ii) the screening procedure of the products identified in question 15(b)(iii) prior to their sale, use or disposal.

16. Please provide the approximate percentage of income you earn from each of the following types of patients:

(a) AIDS/HIV patient	%	(i) Obstetrics/maternity service patients	%
(b) Alcohol and drug treatment or rehabilitation patients	%	(j) Oncology patients	%
(c) Allied health therapy patients	%	(k) Paediatric patient	%
(d) Elective cosmetic surgery patients	%	(l) Senile or aged patients	%
(e) Elective termination patients	%	(m) Surgical patients	%
(f) General/medical patients	%	(n) Tubercular/communicable patient	%
(g) Mental health patients	%	(o) Palliative care patients	%
(h) Neo-natal patients	%	(p) Other (please attach details)	%
		Total	100%

17. Please provide the number of beds maintained by the private hospital (including day surgery beds)

18. Please provide the approximate annual occupancy rate for the last financial year

%

C. Financial details

19. (a) When is your financial year end

(b) What is the amount of gross income for the following:

(i) current financial year (estimate)

\$A

(ii) last financial year

\$A

(iii) previous financial year

\$A

20. Please provide the approximate percentage of your activities (based on gross income/fees) applicable to each State, Territory and Overseas.

NSW	VIC	QLD	SA	WA	TAS	NT	ACT	O/S
%	%	%	%	%	%	%	%	%

D. Claims details

Please answer the following AFTER ENQUIRY of all persons to be insured under this policy:

21. (a) Have any claim(s) been made, or negligence alleged in the last ten (10) years against:

Yes No

(i) you;

(ii) any predecessors in business;

(iii) any prior business of any of your past or present directors, partners or principals;

(iv) any person to be insured under this policy; or

(b) Have any circumstances been notified to insurers that may give rise to a claim?

Yes No

If 'Yes', please provide the following details in respect of each matter.

Date matter notified	Name of insurer (if any)	Name of claimant or potential claimant	Brief description of matter	Amount paid or estimate of potential liability	Is matter finalised or outstanding?
/ /				\$	
/ /				\$	
/ /				\$	
/ /				\$	
/ /				\$	
/ /				\$	
/ /				\$	
/ /				\$	

(c) Are there any circumstances not already notified to insurers which may give rise to a claim against you or any person insured under this policy?

Yes No

If 'Yes', please provide the following details in respect of each matter.

Name of claimant or potential claimant	Brief description of matter	Estimate of potential liability
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$

22. Have you or any of your partners, principals or directors ever been refused this type of insurance or had similar insurance cancelled, or had an application of renewal declined, or had special terms imposed? If 'Yes', please provide details:

Yes No

23. Have you or any of your partners, principals or directors ever been declared bankrupt in the last five (5) years? If 'Yes', please provide details:

Yes No

24. Have you or any of your partners, principals or directors been the subject of administration proceedings in the last five (5) years? If 'Yes', please provide details:

Yes No

25. Have you or any person to be insured under this policy ever been subject to disciplinary proceedings for professional misconduct? If 'Yes', please provide details:

Yes No

26. Have you or any of your partners, principals or directors been convicted of any criminal offence (other than minor traffic convictions) in the last five (5) years? If 'Yes', please provide details:

Yes No

E. Insurance cover details

27. Does the private hospital presently carry or has the private hospital ever carried malpractice liability insurance? Yes No

If 'Yes', please provide details:

Insurer		
Expiry date	/	/
Limit of indemnity	\$	
Premium	\$	

F. Application for cover

28. (a) Limit of indemnity required

\$

(b) Deductible/excess requested (each and every claim)

\$

(c) Optional extensions (please indicate if you seek cover for the following option extensions)

- Aggregated limit of indemnity (reinstatement) Yes No
- Fidelity Yes No
- Previous business Yes No

29. Fidelity cover

(To be completed only if you are applying for the **fidelity extension**)

(a) Does the private hospital presently carry any fidelity guarantee insurance? Yes No

If 'Yes', please provide details:

Insurer		
Expiry date	/	/
Limit of indemnity	\$	
Deductible/excess	\$	

(b) Has the private hospital sustained any loss through the fraud or dishonesty of any employee? Yes No

If 'Yes', please provide details and state precautions taken to prevent a recurrence.

(c) Is any member of the private hospital's staff allowed to handle cash or transferable documents or sign cheques on his/her signature alone? Yes No

(d) How often and by whom are the entries in the cash book checked with vouchers and reconciled with bank statements and returned cheques?

(e) Does the private hospital always require and obtain satisfactory references when engaging employees? Yes No

30. Previous business cover

(To be completed only if you are applying for **previous business extension**)

Name of principal, partner or director seeking previous business cover	Name(s) of previous business(es)	Estimate gross income for previous business(es) for two (2) financial/ calendar year ends immediately prior to principal, partner or director leaving	To the best of your knowledge, does the previous business(es) carry their own current Professional Indemnity or Malpractice Insurance Policy?	Please provide details of the types of professional/medical services offered by the previous business(es)
		\$		
		\$		
		\$		
		\$		
		\$		

Your answers to the claims and circumstances questions in this application form must fully reflect the claims and circumstances history of any prior or previous business.

G. Declaration and authorisation

Please remember we will treat a statement or claim or an act or omission by any one of the applicants as a statement or claim or an act or omission by all of the applicants.

1. I/we have received a copy of the Product Disclosure Statement (PDS) and the Policy Booklet.
2. I/we declare that all answers and statements made in the application are true, correct and complete in every respect.
3. I/we authorise QBE Insurance (Australia) Limited ABN 78 003 191 035 to give to or obtain from other insurers or insurance reference bureaus or credit reporting agencies, any information about this insurance or any other insurance of mine including this completed application and my insurance claims history and my credit history.

Name of private hospital

**Signed: Chief executive officer/
General manager**

Date

/ /

Please return the completed application form to your financial services provider.

This Policy is underwritten by QBE Insurance (Australia) Limited ABN 78 003 191 035 of 8 Chifley Square, Sydney, NSW 2000