

# Treatment of Public Patients

The Professional Indemnity Insurance Policy issued by MDA National Insurance excludes cover for claims arising from the treatment of public patients in public hospitals. If you wish to apply to amend this exclusion you must complete this form.

**NOTE: Prior to completing this form please seek written confirmation from your employer regarding your indemnity status. Please attach a copy of the confirmation to this form.**

As a general principle, we will only agree to provide cover for claims arising from the treatment of public patients in public hospital(s) when you do not have indemnity provided by the hospital(s) and you are not able to elect to be indemnified by the hospital. For example, if you become an employee of the hospital and are paid via the payroll instead of billing through an ABN, you may be entitled to indemnity from the hospital. In this instance, we would not agree to amend the exclusion.

Full Name	Membership Number (if current Member)
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## Practice Details

- 1. Do you provide any medical services to public patients in public hospitals for which you need to arrange your own indemnity for civil claims?**  YES  NO

If NO, you do not need to complete the remainder of this form.

If YES, please confirm the period that you will be providing medical services to public patients in public hospitals. If the work will be ongoing, please leave the end date blank.

Start Date:        /        /        End Date:        /        /

- 2. Please provide a detailed description of your working pattern.**  
For example, do you undertake shifts at the same hospital or at a number of different hospitals, do you undertake occasional shifts throughout the year or do you work on a more regular basis, etc.

- 3. Please list the public hospital(s) you will be working in where you require our indemnity for claims arising from the treatment of public patients and the average number of hours per week in each.**

Hospital	Average Hours Per Week

- 4. Please provide a description of the medical services you provide at these hospitals, including your specialty or field of practice.**

- 5. Please provide the estimated Gross Annual Billings derived from the work you have outlined above.** \$

## Declaration

I confirm that I have requested that the hospital(s) above provide me with indemnity, but I have been advised that I am not eligible for indemnity and that I am not able to elect to be indemnified by the hospital.

## PLEASE SIGN AND DATE HERE

Signed	Date        /        /
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