

Application and Proposal

- Application for Membership of MDA National
- Proposal for Professional Indemnity Insurance

This form includes an application for Membership of The Medical Defence Association of Western Australia (Incorporated) ARBN 055 801 771 trading as MDA National and a proposal for a Professional Indemnity Insurance Policy underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073. Information provided in this form may be used for both purposes.

In completing this proposal, 'we', 'our' and 'us' means MDA National Insurance. 'You' and 'your' means the proposed insured.

It is important that all information contained in this proposal is accurate and complete as this document will form the basis of the insurance contract between you and us. Where there is not sufficient room, please provide your answer on a separate attachment. Failure to disclose all material information that is likely to influence the acceptance of the risk or the terms applied could invalidate the insurance. If you have any doubt as to whether any information is material, it should be disclosed.

Please read the Important Notice on Page 6 before completing this form.

Upon receipt and acceptance of your application and proposal we will send you a quotation and offer of Membership and insurance. Please indicate how you would like to receive this offer.

Email Fax Post

How did you find out about indemnity cover with MDA National Insurance?

Recommendation Internet Event Mailing Advertisement

1. Personal Details

Previous Membership Number (if applicable)

Surname Male Female

Former or Maiden Name Date of Birth / /

First Name Middle Name

Practice Address Preferred

State Postcode

Residential Address Preferred

State Postcode

Practice Telephone () Practice Fax () Mobile

Home Telephone () Home Fax ()

Email

2. Commencement Date

2.1 When would you like your cover to commence?

_____ / _____ / _____

3. Retroactive Cover

Please refer to the Notes to Retroactive Cover section below and/or the relevant Product Disclosure Statement when completing this question. The policy coverage is limited to incidents that occur on or after the retroactive date.

3.1 Do you require retroactive cover?

YES NO

If **NO**, please proceed to question 4.1.

3.2 If **YES**, what retroactive date do you require?

_____ / _____ / _____

3.3 In order for us to assess your risk since your retroactive date, we need to understand the nature and extent of your practice.

Please complete the table below providing all information requested in relation to the periods for which you require retroactive cover.

| Previous Years /Period | Specialty or Field(s) of Practice | Gross Annual Billings* (not your salary) | Position Held Within Hospital (if applicable) e.g. Staff Specialist, Registrar, VMO | Do you have access to indemnity in respect of this work from any other party and if so whom (e.g. employer, MDO, insurer)? |
|------------------------|-----------------------------------|--|---|--|
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* Refer to definition of Gross Annual Billings at question 4.1.

3.4 Since your retroactive date, have you been involved in obstetric or cosmetic# practice?

YES NO

If **YES**, please provide the details.

| Procedures Undertaken | Estimate of Gross Annual Billings* Derived from the Work | Relevant Years/Period |
|-----------------------|--|-----------------------|
| | | |
| | | |
| | | |
| | | |

* Refer to definition of Gross Annual Billings at question 4.1. # Refer to definition of Cosmetic Practice at question 4.5.

Notes to Retroactive Cover

For further information regarding retroactive cover, please refer to the Product Disclosure Statement.

Before we enter into or renew a medical indemnity insurance contract, the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) requires that we make you an offer to provide retroactive cover in relation to all prior periods for which you would otherwise be without medical indemnity cover. Your policy will only respond to matters which result from your practice on or after the retroactive date. The retroactive date will therefore determine how much of your prior practice is covered under your policy. For example, if you request a retroactive date of 1 July 2003, your policy will not cover a matter which arises from your practice prior to this date, even if you first learn about it and report it to us during the period of insurance.

In answering this question, you may need to review your prior indemnity arrangements to determine your retroactive date. In some instances, you may have access to indemnity from your employer, an Area Health Authority, a Government body, or another MDO or insurer and as such you may not need retroactive cover from us for these periods of practice.

We rely on you to tell us if you have any uncovered prior periods.

It is important for you to be aware that if you do not have sufficient retroactive cover, you may have to fund a claim or investigation personally, including any settlement or award and all associated defence costs. You will appreciate that these costs can be considerable. It is therefore advisable to ensure you have the appropriate retroactive date.

4. Your Practice

4.1 Please advise your specialty and all fields of practice for which you require indemnity.

Please refer to the relevant Risk Category Guide to select the category that covers all areas of practise for which you require indemnity cover. If you are unsure of which category to select, please contact our Member Services team on 1800 011 255.

| Specialty or Field of Practice | Sub Specialty | Estimated Gross Annual Billings* (not your salary) | Position Held Within Hospital (if applicable) e.g. Staff Specialist, Registrar, VMO | Do you have access to indemnity in respect of this work from any other party and if so from whom (e.g. employer, MDO, insurer)? |
|--------------------------------|---------------|--|---|---|
| | | | | |
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* Gross Annual Billings are the total billings generated by you from all areas of your practice for which you require indemnity from us within the financial year whether the funds are retained by you or not, and before any apportionment or deduction of expenses and/or tax. This includes work performed in your name or work for which you are personally liable, including but not limited to Medicare benefits, payments by individuals, payments by the Commonwealth Department of Veteran's Affairs, workers compensation schemes and third party insurers. It also includes income received from allied healthcare services provided by you such as professional fees, writing articles, incentive payments and overseas work for which we have agreed to extend indemnity under the policy. You do not need to include billings or income from healthcare services that you provide in the public system for which you have access to indemnity from the public hospital or your employer.

4.2 Do you provide healthcare services to public patients in a public hospital?

YES NO

If NO, please proceed to question 4.4.

4.3 Are you indemnified by your employer, State or Area Health Authority for this practice?

YES NO

If NO, and you require indemnity for this work, please provide us with the nature of the work you undertake by completing the Treatment of Public Patients Form and return it to us with your application. This form is available on our website or by contacting Member Services on 1800 011 255.

4.4 Do you provide any healthcare services that may not be regarded as normal for your specialty or field of practice?

YES NO

If YES, please indicate the nature and extent of such activities.

4.5 Do you perform any cosmetic# procedures?

YES NO

If YES, are these procedures listed under the category you have selected? If not, please describe the procedures undertaken.

Cosmetic procedures are those where the primary purpose is the alteration of the external appearance of a patient for non-pathological reasons.

4.6 Are you involved in obstetric practice?

^Shared care is defined as the joint management of a pregnancy with a specialist Obstetrician or maternity hospital where:

- an intent for a shared care arrangement is made at the initial consultation; and
- evidence exists of referral to a specialist Obstetrician, GP obstetrician or Public Hospital antenatal clinic and of continuing shared care arrangements; and
- there is no involvement, or intention to be involved, with induction or delivery.

- No Obstetric
 Shared care only^
 Collaborative Care arrangement with a midwife
 Obstetric

4.7 Are you visiting or working in Australia for a period of less than 12 months?

YES NO

If YES, please state your last day of practice.

_____/_____/_____

4.8 Are you working in Australia on a visa?

YES NO

If YES:

a) Please indicate which visa applies. 422 457 442

b) Please provide a copy of your visa.

c) Please state your intended departure date, if known. ____/____/_____

d) Please provide below the dates of any previous work you have done in Australia, if applicable.

____/____/_____ to ____/____/_____

5. Qualifications and Registration

5.1 Please list your medical qualifications.

| Qualification Awarded | University/College/Institution | Country | Year Awarded |
|-----------------------|--------------------------------|---------|--------------|
| | | | |
| | | | |
| | | | |

5.2 Have you completed or are you currently completing any AMC accreditation or recognition program? YES NO

If YES, please specify the component or pathway and the completion date or intended completion date below.

| AMC Component/Pathway | Completion Date/Intended Date of Completion |
|-----------------------|---|
| | / / |
| | / / |

5.3 Please list all current college memberships and indicate whether you are currently in the college training program.

| College | Date From | College Training Program |
|---------|-----------|--------------------------|
| | / / | <input type="checkbox"/> |
| | / / | <input type="checkbox"/> |
| | / / | <input type="checkbox"/> |

5.4 Please provide your registration details.

| Country, State or Territory of Registration | Registration Number | Date First Registered in Australia | Expiry Date of Current Registration |
|---|---------------------|------------------------------------|-------------------------------------|
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |

5.5 Have you ever been refused registration, deregistered or suspended from practice as a medical practitioner, whether as a result of a disciplinary proceeding or otherwise? YES NO

If YES, please provide full details on a separate attachment.

5.6 Do you currently have, or have you ever had, conditions, undertakings, reprimands or notations placed on your registration, including restrictions to practice only in a designated 'Area of Need'? YES NO

If YES, please provide a copy of these conditions.

6. Indemnity History

- 6.1** Have you ever been a Member of a Medical Defence Organisation (including MDA National) or held a Professional Indemnity Insurance Policy? YES NO

If YES, please provide details of your previous MDO(s) or insurer(s) for the last 10 years in the table below.

| Name of Organisation/Insurer | From | To |
|------------------------------|------|----|
| Avant | | |
| Invivo | | |
| MDA National | | |
| MIGA | | |
| MIPS | | |
| Other (Please specify) | | |

7. Claims History

- 7.1** Have you ever been refused Membership of a Medical Defence Organisation or been refused professional indemnity insurance or had your insurance or Membership cancelled or not been offered renewal or had conditions imposed on any cover or offer of cover? YES NO
- 7.2** Has any MDO or Medical Indemnity Insurer ever imposed any non standard terms or conditions on your practice or medical indemnity cover, including any requirement that you participate in a risk management program, or have they advised you that such requirements, terms or conditions will be imposed on your current or future indemnity or practice? YES NO
- 7.3** Have you ever had any claims made or threatened against you or a current or previous employer arising from your provision of healthcare services, whether finalised or not? YES NO
- 7.4** Are you aware of any circumstances which may give rise to a claim against you or a current or previous employer arising from your provision of healthcare services? YES NO
- 7.5** Have you ever had any complaints made or threatened against you arising from your provision of healthcare services, whether they have been investigated or not? YES NO
- 7.6** Have you ever been the subject of an investigation, complaint, disciplinary or other proceeding or inquiry by any court, tribunal, board, statutory or other body? YES NO
- 7.7** Have you ever been the subject of a claim or investigation relating to alleged breaches of the *Trade Practices Act 1974* (Cth) or the *Competition and Consumer Act 2010* (Cth) or any equivalent State or Territory fair trading legislation in relation to your provision of healthcare services? YES NO
- 7.8** Have you ever had a finding or a claim made against you in relation to a dispute with an employee, employer (whether past, present or proposed) or a hospital at which you are or were a Visiting Medical Officer? YES NO

If you have answered YES to any question in this section, please provide a detailed description of each matter on a separate attachment. For questions relating to claims, circumstances, inquiries or investigations please include in this description:

- whether the matter was notified to and dealt with by an MDO or insurer and, if so, which organisation;
- the date of the incident;
- a brief summary of the matter and the relevant details (please do not identify the patient in any way);
- your involvement in the matter;
- details of any legal or indemnity payments made, if you are aware of this; and
- the outcome if known (if unknown, please state the last known status).

PLEASE DO NOT SEND ANY ORIGINAL DOCUMENTS WITH THIS PROPOSAL

8. Important Notice

To have a thorough understanding of the cover provided under your policy please read the following information in conjunction with the current Professional Indemnity Insurance Product Disclosure Statement and Policy Wording and relevant Supplementary Product Disclosure Statement.

Your duty of disclosure

Before you enter into a contract of general insurance with an insurer, you have a duty, under the *Insurance Contracts Act 1984* (Cth), to disclose to us every matter that you know, or could reasonably be expected to know, is relevant to our decision whether to accept the risk of insurance and, if so, on what terms. The duty extends up until the time that we issue a policy to you.

You have the same duty to disclose those matters to us before you renew, extend, vary or reinstate a contract of general insurance.

Your duty however does not require disclosure of something:

- that diminishes the risk to be undertaken by us; or
- that is of common knowledge; or
- that we know or in the ordinary course of our business ought to know; or
- when compliance with the duty of disclosure is waived by us.

Non-disclosure

If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the contract of insurance with respect to a claim or may cancel the contract of insurance.

If your non-disclosure is fraudulent, we may also have the option of avoiding the contract of insurance from its beginning.

Claims made cover

The Professional Indemnity Insurance Policy is a claims made contract of insurance. This means that the policy responds to claims made against you and notified to us in writing during the period of insurance.

Rights under section 40(3) of the Insurance Contracts Act

If you have a policy with us and you notify us in writing of circumstances which may give rise to a claim during your period of cover, the fact that you do not give us written notice of a claim relating to those circumstances before your policy has expired will not, of itself, relieve us of liability in relation to the claim. However, you must notify us of a claim, investigation or inquiry as soon as you become aware of it.

You must notify us

You must notify us as soon as practicable of any material alteration of the risk during the period of insurance including any material change in your field of practice or the nature of the professional services provided by you, or the risk category or billings bands you have previously declared.

You must also notify us as soon as practicable after you become aware of:

- any claim, investigation or inquiry; or
- any circumstance that might lead to a claim against you or to an investigation or inquiry involving you.

Privacy

Please note that any information you provide will be held and used by us and any companies, firms or individuals who assist us in providing services (including but not limited to reinsurers, medical specialists, solicitors and barristers) in accordance with the MDA National Group Privacy Policy.

Payments

All monies received will be paid into an Australian bank account and held in trust on your behalf until we agree to accept your proposal. If we do not accept your proposal, all monies will be refunded to you. MDA National is entitled to the interest earned on this bank account.

9. Third Party Disclosure Authority

MDA National Insurance is occasionally requested by a third party to provide details of your current status to confirm that you have indemnity insurance in place. This information is usually requested by hospitals, employers, employees and medical boards. If you wish to enable authorised associated parties, such as your practice managers, to obtain information on your behalf you can nominate a password below and provide it to your associates. The authority provided by you will only apply if your application and proposal is accepted.

9.1 Do you authorise MDA National Insurance to provide confirmation of your indemnity cover to a third party? YES NO

9.2 Do you authorise a Hospital or Practice that you work at to obtain a Certificate of Currency on your behalf? YES NO
If YES, please provide the Hospital or Practice name/s.

9.3 Do you wish to enable authorised associated parties, such as your practice managers, to obtain information on your behalf? YES NO
If YES, please tick the appropriate disclosure preference below and nominate a password.

Information regarding my Membership of MDA National or my Professional Indemnity Insurance Policy issued by MDA National Insurance, but not including any information pertaining to any incidents I have reported to you or claims made against me.

Other (please provide details) _____

PASSWORD (Limit of 8 Characters)

When contacting MDA National Insurance on your behalf, the authorised person will be asked for your password as verification before any information is disclosed. This process will eliminate you having to provide written authorisation for each associate. It is your responsibility to provide your password to associates and keep it confidential. MDA National Insurance will not be responsible for verifying that any person using your password has been properly authorised by you to do so. Your nominated password can be changed at any time by contacting MDA National Insurance and the authorisation will remain current until it is revoked by you.

10. Publications

10.1 If you wish to receive our quarterly publication *Defence Update* by email, please tick this box.

10.2 If you do not wish to receive our quarterly publication *Defence Update*, please tick this box.

11. Application and Declaration - must be signed

Application for Membership

I wish to apply for Membership of MDA National. If my application is approved, I agree to be bound by the Rules of MDA National which are available on request.

I declare that:

1. I have read and understood the Important Notice.
2. I have read and understood the contents of this proposal and acknowledge that the information included in, or attached to, this form is accurate and complete.
3. I will provide evidence of my Gross Annual Billings to MDA National Insurance if requested to do so.
4. I understand my duty of disclosure exists until the contract of insurance is entered into and that I have a continuing obligation to inform MDA National Insurance of any material alteration of the risk during the period of insurance including any change in my field of practice or any material change in the nature of professional services provided by me, or the risk category or billings bands that I have previously declared.
5. I acknowledge that the policy (if issued) will not indemnify me with respect to:
 - (a) claims that have been made against me as at the date of this proposal;
 - (b) claims that arise in the future from matters that I am aware will likely give rise to a claim as at the date of this proposal;
 - (c) any current investigation or inquiry;
 - (d) any future investigation or inquiry that results from a matter that has been or is currently being investigated, as at the date of this proposal; and
 - (e) any matter reported on or with this proposal or matters that should have been reported on or with this proposal.
6. I authorise and request any Medical Board or other registration body to release all information requested by MDA National Insurance regarding my registration as a medical practitioner, any conditions placed upon it and any complaints to, or investigations or hearings by, the Medical Board or registration body involving me whether or not there has been a final resolution and I consent to the disclosure of such information to MDA National Insurance and any of its reinsurers or advisers, as appropriate.
7. I authorise and request my former insurer or indemnity provider to release all information requested by MDA National Insurance regarding all requests for indemnity or assistance including details of claims, complaints, investigations or inquiries involving me, whether or not there has been a final resolution, and I consent to the disclosure of such information to MDA National Insurance and any of its reinsurers or advisers, as appropriate.
8. I consent to MDA National Insurance and any companies, firms or individuals who assist them in providing services including reinsurers, medical specialists, solicitors and barristers, holding and using the information I provide, in accordance with the MDA National Group Privacy Policy.
9. If I am eligible for the PSS, I will participate in and complete within the period of insurance, risk management training and/or activities that MDA National Insurance specify, and I agree to provide information to MDA National Insurance regarding my participation in risk management training or activities and authorise the release of such information to the Australian Government.

Third Party Disclosure Authority

10. I hereby authorise MDA National Insurance to provide the information, as stated in section 9 of this form, to any person providing my privacy disclosure password to us.
11. I am aware that it is my responsibility to keep my password confidential and that MDA National Insurance will not be responsible to verify that any person using my password has been properly authorised by me to do so.
12. I may revoke this authorisation in writing at any time. I may also change my password at any time by contacting MDA National Insurance.

Authorisation and Consent

6. I authorise and request any Medical Board or other registration body to release all information requested by MDA National Insurance regarding my registration as a medical practitioner, any conditions placed upon it and any complaints to, or investigations or hearings by,

Office Use Only

Please Sign and Date Here

Signed _____ Date / /

| Office Use Only | Received | Underwriting | Payment |
|-----------------|----------|--------------|---------|
| | | | |



Freecall: 1800 011 255

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