

Application and Proposal



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

This form includes an application for Student Membership of the Medical Defence Association of Western Australia (Incorporated) trading as MDA National ARBN 055 801 771 and a proposal for a Student Indemnity 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.

1. Personal Details

Current Membership Number (if applicable)		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Surname	Former or Maiden Name		
First Name	Middle Name(s)	Date of Birth / /	
Mailing Address			
		State	Postcode
Telephone ()	Mobile		
Email			
Name of Medical School/University		Country	
Current Year of Study	Expected Year of Final Exams	Type of Degree (e.g. MBBS)	
Existing Qualifications (if applicable)			
University		Year Completed	

2. Application for Membership

I wish to apply for Student 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.

Please Sign and Date Here

Signed	Date / /
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Office Use Only	Received	Underwriting	Payment



Important Notice

Please read the following information carefully before you complete this form.

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)*, 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 Student Indemnity Policy is a claims made contract of insurance. This means that the policy responds to claims notified to us in writing during the period of insurance.

Claim means:

- a) a demand for, or an assertion of a right to, compensation or damages or an intimation of an intention to seek compensation or damages which you first receive or become aware of during the period of insurance; or
- b) a circumstance that might lead to a claim under a) above.

The claims made policy does not cover matters you were aware of prior to the commencement of the period of insurance, whether you told us about them on your proposal or not. Such matters may be:

- claims that have already been made or threatened against you;
- circumstances you are aware of that could give rise to a claim or investigation; and
- investigations whether commenced or not.

This does not mean that claims notified under an existing policy will not continue to be covered under that policy.

Before submitting this proposal you should familiarise yourself with our standard form of policy for this type of cover. The policy wording is contained within the Student Indemnity Policy booklet.

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 or investigation as soon as you become aware of it.

Subrogation

We have a right under the policy to take over all of your rights of recovery in respect of a claim and to pursue actions against third parties in your name even if a claim has not actually been paid.

If you surrender any right or settle any claim for contribution, indemnity or recovery without our prior written consent then we may be entitled to reduce our liability under the contract of insurance.

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 the nature of the services provided by you.

You must also notify us in writing as soon as practicable after you become aware of any claim or investigation.

3. Elective, Scholarship or Clinical Placement Details

Please provide details of any electives, scholarships and/or clinical placements for which you require our indemnity. If you require our indemnity for more than two electives, scholarships or clinical placements, please provide details on a separate attachment.

Please circle: Elective Scholarship Clinical Placement			Period: _____ / _____ / _____ to _____ / _____ / _____		
Name of Hospital/Practice/Placement					
Address					
				State	Postcode
Country (if not Australia)					
Supervisor Name			Supervisor Telephone Number		

Please circle: Elective Scholarship Clinical Placement			Period: _____ / _____ / _____ to _____ / _____ / _____		
Name of Hospital/Practice/Placement					
Address					
				State	Postcode
Country (if not Australia)					
Supervisor Name			Supervisor Telephone Number		

4. Documentation



Please attach to this application written confirmation of your elective, scholarship or clinical placement, including the dates, from your university or scholarship provider (as appropriate). If you are undertaking a clinical placement outside of your university studies, please provide written confirmation from your supervisor of this placement.

5. Indemnity History

- 5.1** Have you ever been refused Membership of a medical defence organisation or been refused insurance or had your insurance cancelled or had an application for renewal declined or had special terms imposed? YES NO
- 5.2** Do you know of any claims against you, or circumstances which may give rise to any claims against you, arising from your conduct as a medical student in the past or present? YES NO
- 5.3** Have you ever been subject to any disciplinary inquiry or proceeding instigated by your university, registration body, hospital or supervisor, or had any complaints made or threatened against you? YES NO

If you have answered YES to any of the questions in this section, please provide a detailed description of each matter on a separate attachment.

PLEASE DO NOT SEND ANY ORIGINAL DOCUMENTS WITH THIS PROPOSAL

6. Declaration - must be signed

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 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 material change in the nature of the services provided by me.

Consent

4. 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.

Please Sign and Date Here

Signed _____ Date / /

7. Third Party Disclosure Authority

If you wish to enable authorised associated parties to obtain information on your behalf you can nominate a password below and provide it to your associates. When contacting MDA National Insurance on your behalf, the authorised person will be asked your password as verification before any information is disclosed. This process will eliminate you having to provide written authorisation for each associate. Your nominated password may be changed at any time by contacting MDA National Insurance.

This authorisation will remain current until it is revoked.

To activate your password, simply complete the sections below. Should you not wish to activate a password, please leave this section blank.

Authority

I hereby authorise MDA National Insurance to provide the information, as stated below, to any person providing my privacy disclosure password to them. (Please tick appropriate disclosure preference).

- Information regarding my Membership of MDA National or my Student Indemnity 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) _____

I am aware that it is my responsibility to keep my password confidential and that MDA National Insurance will not be responsible to check that any person using my password has been properly authorised by me to do so.

I may revoke this authorisation in writing at any time. I may also change my password at any time by contacting MDA National Insurance.

PASSWORD (Limit of 8 Characters)

Please Sign and Date Here

Signed _____ Date / /

Payment Options

All monies received will be paid into an Australian bank account where they will be 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 Insurance is entitled to the interest earned on this bank account.

Full Name	Payment Amount (inclusive of taxes) \$15.00
Membership Number (if known)	

Credit Card

Please complete your credit card details below and return this form to us in the reply paid envelope provided.

AMEX Diners Mastercard Visa

Card Number Expiry Date /

Please Sign and Date Here

Signed	Date / /
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Cheque

I enclose a cheque made payable to MDA National Insurance Pty Ltd to the value above.

Registered Office: MDA National, Level 3, 516 Hay Street, SUBIACO WA 6008 **Phone:** (08) 6461 3400 **Fax:** (08) 9415 1492

Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073. With limited exceptions they are available only to Members of MDA National. MDA National Insurance is a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated) ARBN 055 801 771, trading as MDA National incorporated in Western Australia. The liability of Members is limited.

Privacy: The MDA National Group collects personal information to provide and market our services or to meet legal obligations. We may share personal information with other organisations that assist us in doing this. You may access personal information we hold about you, subject to the Federal Privacy Act. If you wish to change your contact details or be removed from our mailing lists, please contact us at 1800 011 255. For more information or to see our Privacy Policy contact us on 1800 011 255.