

# Practice Indemnity Insurance Proposal



Thank you for your application. By completing this proposal you are applying for a Practice Indemnity Policy underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073.

In completing this proposal, 'we', 'our' and 'us' means MDA National Insurance. 'You', 'your', 'the practice' and 'the applicant' means the practice entity seeking insurance. It is important that you ensure that this insurance proposal is accurate and complete. The information requested in this form is used by us for the purpose of considering whether or not to insure you and, if so, on what terms. If there is insufficient room on the application, please provide your answer on a separate attachment. Failure to disclose material information relevant to our decision to accept your application and the terms of insurance could invalidate the insurance contract. If you have any doubt as to whether any information is relevant it should be disclosed.

**Please read the Important Notice on page 5 before completing this form.**

## 1. Practice details

**Please complete all information in BLOCK LETTERS**

Full legal name of entity to be insured

Trading names

Trading since

ABN/ACN

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Entity type  Company  Partnership  Sole trader  Trust

Practice address

Postcode

Postal address

Postcode

Telephone ( )

Fax ( )

Email

Website

Address of all other practice locations

Postcode

Postcode

**1.1** Is this practice owned by another entity? If **YES**, please provide details.

YES

NO

**1.2** Please provide details of any related entities owned by the practice.

Please list the relationship with the entity to be insured. For example, subsidiary, branch.

Name ABN/ACN 

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 relation

Name ABN/ACN 

--	--	--	--	--	--	--	--	--	--

 relation

Name ABN/ACN 

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 relation

**Upon receipt and acceptance of your proposal we will send you an offer of insurance.**

**Please indicate how you would like to receive this offer.**

Email

Fax

Post

## 2. Authorised person

Please provide details of the person authorised by you to arrange, renew or vary the policy and to discuss with us any relevant details.

Title Full name

Position

Telephone ( )

Email

### 3. Coverage requirements

**3.1** Has the practice held professional indemnity insurance in the past?  YES  NO  
 If YES, please provide the following details.

Insurer	Date of Expiry	Retroactive Date	Limit of Indemnity	Excess or Deductible
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

**3.2** What date do you want the policy to commence? / /

**3.3** Do you require retroactive cover for any prior periods before the commencement date of the policy?  YES  NO  
 Please refer to the Important Notice for further information on retroactive cover.  
 If NO, the retroactive date will be the start date of the policy.  
 If YES, please state the retroactive date required. / /

**3.3** Please select your preferred policy limit  \$10,000,000 in the aggregate with a maximum of \$5,000,000 for any one claim  
 \$20,000,000 in the aggregate with a maximum of \$10,000,000 for any one claim

### 4. Practice services

**4.1** Please provide a full description of healthcare services provided by the practice for which you require indemnity.  
 Include here any healthcare services provided that may not be regarded as normal for the type of practice.  
 If you do not list the complete range of services provided, they may not be covered.

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**4.2** Is the practice currently accredited by a registered accreditation body? If so, by whom?  YES  NO  
 (For example, AGPAL, GPA Accreditation plus, ISO).

**4.3** Does the practice have documented policies and procedures for the following?  YES  NO

- Complaints management
- Information security and privacy
- Clinical risk management

**4.4** Does the practice provide any of the following services?  YES  NO

- Obstetric services other than shared care\*
- Fertility treatment
- Clinical trials or research projects
- Cosmetic services (Cosmetic services are those where the primary purpose is the alteration of the external appearance of a patient for non-pathological reasons.)
- Complementary medicine or alternative therapies
- Day Surgery

\* Shared care is defined as the joint management of a pregnancy with a specialist Obstetrician, GP obstetrician or maternity hospital where evidence exists of referral to a specialist Obstetrician, GP obstetrician or Public Hospital antenatal clinic and there is no involvement, or intention to be involved, with the induction or delivery.

Please provide a full description of the services provided including whether those services are provided by medical or dental practitioners or other clinical staff.

Name	Specialty	Description of Services

**4.5** Is the practice participating in or does it intend to participate in the Personally Controlled Electronic Health Record (PCEHR) Scheme?  YES  NO

**4.6** Does the practice provide or has the practice ever provided healthcare services outside Australia?  YES  NO  
If YES, please provide a full description.

**4.7** Within the next twelve months are there any plans to increase the size or scope of the practice?  YES  NO  
If YES, please describe the plans below (for example, new practice locations or the provision of new healthcare services).

**4.8** What is the gross annual turnover\* of the practice (please declare a gross figure)?

Last financial year

Estimate of current financial year

\* The annual turnover of an entity is the total gross income that derives in the financial year in the course of carrying on a business. Please include billings generated by all healthcare professionals and clinical staff employed or contracted by the practice prior to any apportionment or deduction of expenses and/or tax.

**4.9** Please provide a breakdown of your estimated annual turnover based on state/territory.

NSW	VIC	WA	SA	QLD	TAS	ACT	NT
%	%	%	%	%	%	%	%

## 5. Staff profile

### 5.1 Health Professionals

Please provide details of all Medical and Dental Practitioners who work for and on behalf of the practice.

Name	Specialty	MDA National Member (Please tick)	Obstetric# Services?	Full Time (6 - 10 sessions* per week)	Part time (1 - 5 sessions* per week)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* 1 session = half a day

# Obstetric Services means practice as a GP Obstetrician or Specialist Obstetrician

## 5.2 Clinical Staff

Please provide details of all clinical staff who provide healthcare services for or on behalf of the practice. Please do not include any clinical staff whose only relationship to the practice is as a tenant.

Clinical staff	Total number of employees	Total number of contractors	Clinical staff	Total number of employees	Total number of contractors
Audiologist			Nurse - Midwife		
Beauty Therapist			Nurse - Practitioner		
Cardiac Technician			Nurse - Registered/Enrolled		
Chiropractor			Optometrist		
Counsellor			Orthoptist		
Dental Hygienist/Therapist			Osteopath		
Dental Technician/Prosthetist			Physiologist		
Diabetes Educator			Physiotherapist		
Dietician			Podiatrist		
Exercise Physiologist			Psychologist		
Laboratory Technician			Radiographer		
Medical Radiation Practitioner			Scientist		
Naturopath			Ultrasonographer		
Nurse - Cosmetic			Other (please specify)		

## 5.3 Other staff

Please provide details of all other staff. Other staff are those that are not involved in the clinical treatment of patients.

Other staff	Total number employed by practice	Other staff	Total number employed by practice
Practice manager		Other (please specify)	
Reception or administration staff		Other (please specify)	

## 6. Registration and indemnity history

You are required to make due enquiry from each person whose name appears in this proposal before answering this section.

- 6.1** In the last 10 years, has the practice had any claims made against it in connection to the provision of healthcare services?  YES  NO
- 6.2** Have there been any incidents or circumstances within the practice which may give rise to a claim, complaint or investigation including matters you have notified to an insurer as a possible claim?  YES  NO
- 6.3** Does any health professional (Medical or Dental Practitioner), allied health professional or clinical staff member at the practice currently have or have ever had any conditions, undertakings, reprimands or notations placed on their registration including a requirement to be supervised or mentored?  YES  NO
- 6.4** Have any health professionals (Medical or Dental Practitioners), allied health professional or clinical staff been the subject of a mandatory notification to the Australian Health Practitioner Regulation Agency (AHPRA)?  YES  NO

If you answered YES to questions 6.1 to 6.4, please provide details in the table below. Please also include all incidents likely to give rise to a claim or investigation, even if no claim or investigation has been made. Where there is insufficient room, please provide details on a separate attachment or a claims history from your current insurer.

Date of incident	Description of the matter	Total cost of matter including legal fees	Date you first became aware of the matter	Has the matter been reported to an insurer or MDO?	Name of Insurer or MDO to whom this matter has been notified to and accepted by
/ /			/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	
/ /			/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	
/ /			/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	
/ /			/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	

**6.5 Do all health professionals (Medical and Dental Practitioners) in the practice hold their own individual professional indemnity insurance?**  YES  NO

Note: It is a condition of the policy that the practice must ensure that all health professionals maintain their own professional indemnity insurance policies.

**6.6 Has the practice ever had an application for this type of insurance declined, not approved or approved subject to special terms or conditions being imposed?**  YES  NO

**6.7 Has the practice ever had this type of insurance cancelled, not renewed or renewed only with special terms or conditions being imposed?**  YES  NO

If you have answered YES to questions 6.5 to 6.7 on this page, please provide a detailed description of each matter on a separate attachment.

Please do not send any original documents with this proposal

## 7. Important notice

To have a thorough understanding of the cover provided under your policy, please read the following information in conjunction with the current *Practice Indemnity Policy Combined Financial Services Guide, Important Information and Policy Wording* and any *Supplementary Financial Services Guide, Important Information and Endorsement to Policy Wording* available at [mdanational.com.au](http://mdanational.com.au).

### Your duty of disclosure

Before you enter into an insurance contract, you have a duty, under the *Insurance Contracts Act 1984* (Cth) to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to insure you and on what terms. You have this duty until we agree to insure you. You have the same duty before you renew, extend, vary or reinstate an insurance contract.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

### If you do not tell us something

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay if you make a claim, or both.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

### Claims made cover

The Practice Indemnity Policy is a claims made contract of insurance. This means that the policy responds to matters that have occurred on or after the retroactive date and that you first become aware of, and notify to us in writing during the period of insurance.

### Retroactive cover

The policy coverage is limited to incidents that occur on or after the retroactive date.

Your policy will not cover a claim arising from an incident that occurred prior to this date. Please ensure that the retroactive date you select is sufficient and that you have no otherwise uncovered periods for which you require indemnity insurance. You may request a change to your retroactive date at any time.

### Requirement to notify us

You must notify us as soon as practicable of any material alteration in the risk during the period of insurance including, but not limited to, any significant expansion of the practice and any material change in the nature of the practice or the healthcare services provided by you or any insured persons.

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

- any claim or investigation; and
- any circumstance that might lead to a claim, complaint or investigation involving you or an insured person.

### 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.

### 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 renewal/proposal, all monies will be refunded to you. MDA National Insurance is entitled to the interest earned on this bank account.

## 8. Declaration - your signature is required

### I declare that:

1. I am authorised by the applicant to sign this proposal.
2. I have read and understood the contents of this proposal and acknowledge that the information included within, or attached to, this form is accurate and complete.
3. I acknowledge that I have been provided with access to the Financial Services Guide (FSG), Important Information and Policy Wording and on behalf of the applicant I agree to be bound by the terms and conditions of the policy.
4. I understand that the applicant's duty of disclosure exists until the contract of insurance is entered into and that they have a continuing obligation to inform MDA National Insurance of any material alteration of the risk during the period of insurance including any significant expansion of the practice (whether by acquisition of another business or otherwise), any material change to the nature of the practice and the healthcare services provided by the practice or employees of the practice as well as any other change which alters or is likely to alter the risk.
5. I acknowledge that the policy (if issued) will not provide indemnity with respect to:
  - a) claims that are made against the practice or an insured person prior to the commencement of the policy;
  - b) circumstances that the practice or an insured person was aware of prior to the policy commencing which will likely give rise to a claim; and
  - c) all matters disclosed in this proposal or matters that should have been disclosed in this proposal.

### Authorisation and consent

6. The practice authorises and requests its current and former insurer to release all information requested by MDA National Insurance regarding all requests for indemnity or assistance including details of claims, complaints, investigations or inquiries, whether or not there has been a final resolution, and the applicant consents to the disclosure of such information to MDA National Insurance and any of its reinsurers or advisers, as appropriate.
7. The practice consents 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 the applicant provides, in accordance with the MDA National Group Privacy Policy.

### Please sign and date here

Signed

Date / /

Name

Position

### Medical and Dental Practitioner list

Anaesthetist	Ophthalmologist
Dermatologist	Paediatrician
Dentist (solely dental focus)	Pathologist
Gastroenterologist	Physician
General Practitioner	Psychiatrist
General Practitioner (Obstetrics)	Radiologist
Geriatric Medicine Doctor	Sports Physician
Gynaecologist (no Obstetrics)	Surgeon (Consulting only)
Medico-legal Adviser	Surgeon (General)
Neurosurgeon	Surgeon (Orthopaedic)
Obstetrician & Gynaecologist	Surgeon (Plastic and Reconstructive, including Cosmetic)
Occupational Medicine Doctor	Travel Medicine Doctor

Note: If there are health professionals not listed above, please provide details in the relevant staff profile section on page 3.

**Freecall:** 1800 011 255    **Member Services Fax:** 1300 011 244    **Email:** [peaceofmind@mdanational.com.au](mailto:peaceofmind@mdanational.com.au)    **Web:** [mdanational.com.au](http://mdanational.com.au)  
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