Tego Entity Medical Malpractice Insurance Application Form

This is an application form for a Practice Medical Indemnity Policy.

Important facts relating to this application form

DUTY OF DISCLOSURE

Before you enter into an insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, 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 you 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 AND NOTIFIED BASIS OF COVERAGE

Cover under all Sections of the Policy (other than 'Section 3: General Liability' and Section 4: Products Liability') is provided on a "claims made" basis. This means that the Insuring Clause responds to:

(a) claims first made against you during the policy period and notified to the insurer during the policy period, provided that you were not aware at any time prior to the policy inception of circumstances which would have put a reasonable person in your position on notice that a claim may be made against him/her; and:

(b) written notification of facts pursuant to Section 40(3) of the Insurance Contracts Act 1984. The facts that you may decide to notify are those which might give rise to a claim against you. Such notification must be given as soon as reasonably practicable after you become aware of the facts and prior to the time at which the policy expires. If you give written notification of facts the policy will respond even though a claim arising from those facts is made against you after the policy has expired.

When the policy period expires, no new notification of claims or facts can be made on the expired policy even though the event giving rise to the claim against you may have occurred during the policy period. An exception to this is under the extended reporting period extension. If an extended reporting period is purchased as provided for in the extension, then some cover for new notification of claims or facts may be available.

RETROACTIVE DATE

You will not be entitled to indemnity under your new policy in respect of any claim resulting from an act, error or omission occurring or committed or alleged to have occurred or been committed prior to the retroactive date, where one is specified in the policy terms offered to you.

All questions must be fully answered and all requested information and/or required attachments submitted to enable a quotation or indication to be given. However, the completion and submission of this form does not bind the applicant or underwriters to enter into any contract of insurance.

PRIVACY STATEMENT

We collect Personal Information (as defined by the Privacy Act 1988) to provide, offer and administer our various products and services, or otherwise as permitted by law. Such purposes include responding to your enquiries, providing you with assistance, maintaining and administering our products and services (for example processing requests for quotes, applications for insurance, underwriting and pricing policies, issuing you with a policy, managing claims, processing payments); processing your survey or questionnaire responses; market research and the collection of general statistical information using common internet technologies such as cookies; providing you with marketing information regarding other products and services (of ours or a third party); quality assurance and training purposes; performing administrative operations (including accounting and risk management) and any other purpose identified at the time of collecting your information.

We will only collect Sensitive Information (as defined by the Privacy Act 1988) where it is relevant to underwriting an insurance policy or dealing with, managing, or processing a claim.

We may use or disclose Your Personal Information by giving it to related companies and our appointed third parties for research and analysis, to design, test or underwrite new insurance products or features and for subsequent follow up of quotations.

Your Sensitive Information will not be used or disclosed for any other purpose unless we have your permission. If you do not consent to us collecting, using or disclosing all or some of the Personal Information we request, we may not be able to provide you with our products or services such as processing your application for insurance, your claim or any payment due to you. It may also prevent us from maintaining or administering your policy or the provision of information regarding our products or services or those of any third party.

We are committed to protecting your privacy in accordance with the Privacy Act 1988 (Privacy Act). Our Privacy Policy follows the principles set out in the Privacy Act and explains our policies and practices in relation to the handling and use of Personal Information. Our Privacy Policy can be viewed in full on our website – www.tego.com.au, or you can ask our office for a printed copy.

If you have any questions, suggestions or complaints about our privacy practices (including a complaint about a breach of the Privacy Act or Australian Privacy Principles) or this Privacy Policy, You can either email our privacy officer at clientsupport@tego.com.au or write to Tego Insurance Pty Ltd, Attn: Privacy Officer, Level 11, 309 Kent Street, Sydney, NSW, 2000. We will respond to your question, suggestion or complaint as soon as possible.

GUIDELINES TO HELP YOU COMPLETE THIS APPLICATION FORM

1. 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 are in any doubt as to whether any information is material, it should be disclosed.
2. Where the space provided is insufficient for your replies, please provide these separately and attach to this Application Form.
3. Reference to Insured in this Application Form means:
   - the entity or entities named in question 1; and
   - the past and/or present employees, sole practitioners, partners or directors of the entity or entities named in question 1.

INSURED DETAILS

1. Name and ABN of all entities to be insured (e.g. parent company or trustee).

   It is essential to specify the names of all entities that you wish to be covered by this policy.

Name	*Trading name*	*ABN*	*Date business was established*
			/ /
			/ /
			/ /
			/ /
			/ /

   If more than 5 entities please provide details of the corporate structure, listing all entities you require cover for and the responsibility of each entity. (E.g. whether the entity employs staff, leases the premises)

2. Insured website:

3. Insured address(es):

Address	*State*	*Postcode*

4. Telephone and email address of Insured:

Telephone	*Email address*

5. Please provide details of all directors, principals and partners of the Insured:

Name	*Age*	*Qualifications*	*Date qualified*	*How long practising*
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

6. Type of healthcare / medical establishment:

7. Your policy covers healthcare services disclosed to us – please provide a full description of healthcare services to be covered.

8. Please state the number of people in the following categories using the split between employees and others (e.g. self employed doctors or contractors).

Profession/Activity	Full time employees	Part time & casual employees	Contractors
Administration			
Beautician			
Chinese Medicine Practitioner			
Chiropractor			
Counsellor/Social Worker			
Dental Practitioner			
Fertility Specialist			
General Practitioner			
Management			
Midwife			
Nurses (excluding midwives)			
Nurses (cosmetic)			
Other (please specify)			

Profession/Activity	Full time employees	Part time & casual employees	Contractors
Nursing/Personal Care Assistant			
Occupational Therapist			
Optometrist			
Osteopath			
Pathologist			
Physician			
Physiotherapist			
Podiatrist			
Radiologist			
Sonographer			
Surgeon			
Technician			
Other (please specify)			

9. Does the practice undertake any of the following services?

Anaesthetic services	Yes ◯	No ◯
Clinical trials	Yes ◯	No ◯
Cosmetic services	Yes ◯	No ◯
Day surgery	Yes ◯	No ◯
Obstetrics services (not including shared antenatal care)	Yes ◯	No ◯
Termination of pregnancy	Yes ◯	No ◯

If Yes, please provide details (for cosmetic services please provide details of all treatments provided):

10. Please provide further details of the medical and dental practitioners engaged by the Insured:

Title	*Name*	*Category of practice*	*Status (director, employee, contractor, room rental)*	*Insurer*

11. Does the practice hold formal accreditation? (e.g. AGPAL, GPA, APA etc) Yes ◯ No ◯

If yes, please provide details:

12. Does the practice employ a full-time practice manager? Yes ◯ No ◯

If yes, please provide details:

Name	*Qualifications*

13. Has the Insured's membership or registration with any association or professional body ever been declined, withdrawn, suspended or had conditions imposed? Yes ◯ No ◯

14. Do you have any employees or contractors that have conditions, limitations or undertakings on their registration? Yes ◯ No ◯

If yes, please provide details:

15. Do you have written policies and procedures in place to cover the practice for employee terminations, harassment, anti-discrimination and equal opportunity issues that may arise? Yes ◯ No ◯

If no, please provide details of how human resources issues are managed by the practice:

16. If patients stay overnight at the Insured's premises, please state the total number and average daily occupancy for the following:

	Previous Year		**Current Year**	
Category of Beds	*Number*	*Average daily occupancy*	*Number*	*Average daily occupancy*
Bassinettes/Cribs/Cots				
Day Surgery				
Emergency				
Intensive Care				
Maternity				
Nursing Home				
Other				
Self-Care Units				

17. If providing obstetric/maternity services, please state the number of deliveries annually:

Single Births	*Multiple Births*	*Stillborn*

18. Please provide details of the gross annual revenue for the practice in the table below, ensuring declared figures include total revenue from all streams of income.

Next financial year (estimate)	$
Current financial year (annualised)	$
Last financial year (actual)	$

19. Please advise percentage of annual revenue by State/Territory:

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

HEALTHCARE SERVICES

20. Please provide the percentage of how the Insured's gross revenue is derived from each of the following:

Aged Care	%	Haematology	%
Allied Health	%	IVF/Assisted Conception	%
Bariatrics	%	NDIS Coordinator	%
Cardiology (interventional)	%	Nephrology	%
Cardiology (non-interventional)	%	Neurology	%
Day Hospital (cosmetic)	%	Oncology	%
Day Hospital (general)	%	Ophthalmology (consulting/minor procedures)	%
Day Hospital (ophthalmology)	%	Orthopaedic	%
Dentistry (no orthodontics)	%	Otolaryngology	%
Dentistry (orthodontics)	%	Paediatrician	%
Dermatology	%	Psychiatry	%
Disability & Complex Care Provider	%	Medical Imaging (obstetrics)	%
Gastroenterology	%	Medical Imaging (no obstetrics)	%
General Practice (family practice)	%	Rehabilitation	%
General Practice (skin cancer clinic)	%	Respiratory and Sleep Medicine	%
General Practice (cosmetic non-surgical)	%	Rheumatology	%
General Practice (cosmetic surgical)	%	Sports and Exercise Medicine	%
Gynaecology (no fertility)	%	Urology	%
Other (please specify)*		Other (please specify)*	
	%		%

21. Does the practice intend to change the healthcare services it provides in the next 12 months? Yes ◯ No ◯
If yes, please provide details:

22. Has the practice conducted other healthcare services in the past, which have not been described above for which you require cover? Yes ◯ No ◯
If yes, please provide details:

CLAIMS INFORMATION AND INSURANCE HISTORY

23. Have any claims or losses either been made against, or incurred by, the practice during the last 10 years? Or, after appropriate investigation, is the practice aware of any incidents or events which may lead to a claim or loss that could be covered by this policy? Yes ◯ No ◯

If yes, please provide details:

Date of incident	*Date of claim*	*Details of matter*	*Total value of claim (including defence costs)*
/ /	/ /		$
/ /	/ /		$
/ /	/ /		$
/ /	/ /		$
/ /	/ /		$

24. If Yes to 23, what action has been taken to prevent a recurrence of the situation which gave rise to each claim or loss?

25. Has the practice held professional indemnity insurance in the past? Yes ◯ No ◯

If Yes, please provide details below:

Insurer	*Policy period*	*Retroactive Date*	*Limit ($m)*	*Deductible*	*Premium*
		/ /	$	$	$
		/ /	$	$	$
		/ /	$	$	$

26. Has the practice ever had an application or renewal for professional indemnity refused, a loading or special condition placed on insurance, or been offered or provided with a reduced level of cover? Yes ◯ No ◯

If yes, please provide details:

INSURANCE REQUIREMENTS

27. What date do you wish the policy to commence?

/ /

28. What limit and excess of entity medical malpractice do you require?

Limit	$1m ☐	$5m ☐	$10m ☐	$20m ☐
Excess	Nil ☐	$2,500 ☐	$5,000 ☐	$10,000 ☐

Tego provides optional additional covers which can be included within this insurance policy. If you would like us to include any of these optional covers in your quotation, please complete the relevant section below.

PUBLIC LIABILITY **$10,000,000** ◯ **$20,000,000** ◯ **NOT REQUIRED** ◯

29. *Building Address* *Owner/Leased*

30. Does the Insured sub-contract out to other parties any functions of your business? Yes ◯ No ◯

31. Does the Insured ensure that all sub-contracts have current liability insurance in place? Yes ◯ No ◯

32. Does the Insured perform any offsite activities (e.g. patient transport)? Yes ◯ No ◯
If yes, please provide details:

PRODUCTS LIABILITY **$10,000,000** ◯ **$20,000,000** ◯ **NOT REQUIRED** ◯

33. Do you import any products? Yes ◯ No ◯
If yes, where are the products manufactured?:

Do you maintain rights of recourse against the manufacturer? Yes ◯ No ◯

34. Do you manufacture, alter, repair or repackage any products? Yes ◯ No ◯
If yes, please provide details:

FIDELITY COVER **$50,000** ◯ **NOT REQUIRED** ◯

35. Do all cheques drawn for more than $5,000 require at least two signatures? Yes ◯ No ◯
If no, please provide details:

36. Is cash-in-hand, petty cash and bank reconciliation checked independently of those employees responsible for cash, or to deposit into or withdraw from bank accounts? Yes ◯ No ◯
If no, please provide details:

37. Are bank statements, receipts, counterfoils and supporting documents checked at least monthly against the cash book entries independently of those employees making cash book entries or paying into the bank? Yes ◯ No ◯
If no, please provide details:

38. Are those employees who receive cash and cheques in the course of their duties required to pay in daily? Yes ◯ No ◯
If no, please provide details:

NSW STAMP DUTY EXEMPTION DECLARATION (COMPLETE IF APPLICABLE)

46. If the insured's practice is in NSW and meet certain criteria, it may be eligible for stamp duty exemption on the practice insurance premium.

I declare that:

i. The Insured is a small business owner within the meaning of Section 152-10 (1AA) of the ITAA 1997 of the Commonwealth for the income year in which the insurance is effected or renewed. Yes ◯ No ◯

ii. The Insured is carrying on a business with a turnover of less than $2 million in the last financial year. Yes ◯ No ◯

iii. The Insured will undertake to inform you if the Insured's small business status changes in the future, i.e. if the Insured's turnover exceeds $2 million per annum. Yes ◯ No ◯

DECLARATION

This declaration must be completed by either a director, chief executive officer, chief financial officer, practice manager or duly authorised person of the practice.

I am authorised by the Insured to sign this application form on its behalf.

I declare that all answers and statements made in this application are true and correct and that this information will be relied upon in deciding whether to provide an insurance contract and on what terms and conditions.

I understand I have a duty under the Insurance Contracts Act 1984 that means that before I enter into this Policy the Insured must disclose to the Insurer every matter that the Insured knows, or could reasonably be expected to know, that is relevant to the Insurer's decision to accept the Policy and, if so, on what terms and if the practice fails to comply with that duty the Insurer may refuse or reduce its liability for a claim or cancel the Policy.

I consent to the collection, use, storage and disclosure of personal information in the Privacy Policies of Tego Insurance Pty Ltd as available on the website.

I authorise Tego Insurance Pty Ltd to obtain from other insurers, insurance reference bureaus or similar organisations any information about this insurance or any other insurance of mine including the information in this application and my insurance claims history.

Name

Signed

Title

Date

/ /