MDA National
Support Protect Promote

Treatment of Public Patients Proposal

The Professional Indemnity Insurance Policy (the Policy) issued by MDA National Insurance covers claims that arise from the treatment of public patients in public hospitals **only** when we have agreed to in writing. Please detail on this form the nature and extent of services you provide in a public hospital setting for which you require indemnity from us.

Prior to completing this form, you should confirm with your employer your indemnity status. If you have access to indemnity through your employer, cover from us for claims arising from the treatment of a public patient in a public hospital may not be necessary. If we agree to extend cover for the treatment of public patients in the public hospital an additional premium may be payable.

Name*

Member number*

Speciality or field of practice*

Practice details

1. Indicate the period that you will be providing public healthcare services for which you are required to arrange your own indemnity for civil claims.

If the work will be ongoing, please leave the end date blank.

Start date:* DD / MM / YYYY

End date: DD / MM / YYYY

2. List the public hospital(s) that you will be providing these healthcare services at.*

3. Provide a description of the healthcare services you will be providing.*

If you are a Doctor in Training (hold indemnity under the Post Graduate or Doctor in Specialist Training categories) will you:

a) **be supervised for this practice by an appropriately qualified medical practitioner?** ◯ YES ◯ NO

b) **be undertaking Treatment of public patients for which you require indemnity from MDANI for more than 60 days total in the Policy period.** ◯ YES ◯ NO

4. Will the healthcare services you provide include any obstetrics services?
If **YES**, please provide full details of the extent of these services.

◯ YES ◯ NO

5. Provide the total estimated billings you will be generating from the treatment of public patients in the public hospital.

$

6. Are these billings in addition to the total estimated gross annual billings you have provided us?
Please check your **Certifcate of insurance** for the current estimate you have provided.

◯ YES ◯ NO

7. How many sessions per week, on average, will you be undertaking this practice?
(1 session = half day)

Declaration

I confirm that I do not have access to indemnity from the hospital(s) for the services outlined above and that the above is an accurate reflection of public healthcare services that I provide and for which I am required to arrange my own indemnity.

Please SIGN and DATE below

X SIGN HERE DD / MM / YYYY

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