



# MEDICAL MALPRACTICE PROPOSAL

## IMPORTANT NOTICE

### MATERIAL FACTS

“You” (this includes every person or entity to be insured under this insurance) are under a duty to disclose all material facts that could influence QBE’s decision to accept this insurance and, if so, on what terms. You need to disclose both facts known to you AND facts which you could have been reasonably expected to know about. If you are in any doubt as to whether a fact may be material, you should disclose it to ensure that any cover granted is not prejudiced.

### NON DISCLOSURE/MISSTATEMENT

If you fail to comply with your duty of disclosure, QBE may be entitled to avoid the contract altogether, and so decline to pay any claim.

### JURISDICTION

Except to the extent otherwise provided in any subsequently issued policy, the content and use of this form and any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by the laws of New Zealand and in relation to those matters, the parties submit to the jurisdiction of the courts of New Zealand.

### COMPLETION NOTES

- This Proposal Form should be submitted together with the appropriate supplementary questionnaire, either ‘Health Professionals’, ‘Hospitals’ or ‘Private Care Facilities’.
- Please answer ALL questions fully. If you need extra space please attach additional pages on your company letterhead and mark their inclusion in section I of this form.
- **PLEASE ENSURE YOU READ AND SIGN THE DECLARATION.**

## A APPLICANT DETAILS

1 Name(s) in full of all entities to be insured

2 Physical address

3 Website address

## B COVER REQUIRED

1	Limit of Indemnity	\$	<input type="text"/>
2	Excess	\$	<input type="text"/>
3	Period of insurance: From 4pm	<input type="text" value="/"/>	<input type="text" value="/"/>
			to 4pm <input type="text" value="/"/>
4	Broker: Individual	<input type="text"/>	Company <input type="text"/>

## C OPTIONAL EXTENSIONS

1 Do you require any of the following optional extensions to cover?

(a) Libel & Slander	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(b) Loss of Documents	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(c) Dishonesty of Employees	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(d) Fidelity	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(e) Previous Business	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(f) Outgoing Principals	Yes <input type="checkbox"/>	No <input type="checkbox"/>



D BUSINESS DETAILS

1 Please provide a full description of your business activity

Three empty text boxes for business activity description.

2 Date on which the business was established

Empty text box for business establishment date.

E FINANCIAL DETAILS

1 Please provide details of your turnover including funding and any other additional income:

(a) Current Year \$ [text box]

(b) Next Year \$ [text box]

F RISK MANAGEMENT DETAILS

1 Have you implemented any formal risk management procedures or plans?

Yes [checkbox] No [checkbox]

If Yes, (a) is adherence to these procedures periodically reviewed?

Yes [checkbox] No [checkbox]

(i) If Yes, how often? [text box] months

(b) are identified breaches rectified?

Yes [checkbox] No [checkbox]

2 Where relevant, can you confirm that remedial action has been taken to prevent recurrence of any circumstances detailed in section G below.

Yes [checkbox] No [checkbox]

G CLAIMS EXPERIENCE

1 Have any claims been made in the last five years against the applicant or any employee or medical professional engaged by it, alleging negligence or malpractice in the last five years?

Yes [checkbox] No [checkbox]

If Yes, please provide full details

Five empty text boxes for claim details.

H PRIOR INSURANCE

1 Does the applicant presently carry, or has the applicant ever carried, Professional Indemnity insurance?

Yes [checkbox] No [checkbox]

If Yes, please provide full details

Insurer [text box] Expiry Date [text box] / [text box] / [text box]

Limit of Indemnity \$ [text box] Excess \$ [text box] Premium \$ [text box]

2 After enquiry, has the applicant or any employee or medical professional engaged by the applicant, ever been refused this type of insurance or had similar insurance cancelled or had an application for renewal declined or special terms imposed?

Yes [checkbox] No [checkbox]

If Yes, please provide full details

Five empty text boxes for insurance details.



I ENCLOSURES

If relevant, please provide copies of the following and tick to indicate enclosure

- Brochures or other promotional material describing your activities or services
- Hold-harmless agreements
- Other agreements which waive any legal rights or entitlements which you have against consultants, sub-contractors or agents
- Other (please specify)

DECLARATION

I/We declare on behalf of all proposed insureds that:

- (a) all answers and statements in this proposal are correct and complete in every respect and there is no further information which may affect acceptance of the proposal;
- (b) If accepted by QBE, this proposal and declaration, and any other material which I/we have provided to QBE, shall be incorporated into and form the basis of the contract of insurance;
- (c) I/We understand that QBE requires this information (which will be retained by QBE) in order to decide whether to accept this proposal, and also that the Privacy Act 1993 entitles me/us to have access to and request the correction of this information;
- (d) QBE is authorised to disclose information received from me/us to its advisors, reinsurers and to other insurers. I/We authorise QBE to obtain, from any party, information that is, in QBE's view, relevant to this proposal;
- (e) I/We understand that the insurance will not be in force until this proposal has been accepted and cover confirmed by QBE.

NOTE: Signing the proposal and any supplementary questionnaires does not bind either the applicant or QBE to complete the insurance.

Signed

Printed name

Position

Date



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