HEALTH PROFESSIONALS

SUPPLEMENTARY QUESTIONNAIRE

IMPORTANT NOTICE

This Supplementary Questionnaire forms a key part of your Medical Malpractice Proposal and it is important that all material facts continue to be fully, frankly and accurately disclosed.
PLEASE REMEMBER TO SIGN AND DATE THIS FORM.

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.

Name of Applicant

Name of Broker

A EMPLOYEE DETAILS

1. Please provide total number of employees in each of the following classifications:

Classification	Number employees
Doctors	
Dentists	
X-Ray Technicians	
Lab Technicians	
Pharmacists	
Registered Nurses	
Undergraduate/Student Staff	
Other medical or allied health employees	

B ESTABLISHMENT DETAILS

1. Do you ensure that all doctors of medicine (whether employed or visiting) who provide medical services for or use the facilities of, the Business are members of a recognised Medical Defence Union/Association or Protection Society, or otherwise carry their own Medical Malpractice insurance? Yes ☐ No ☐
2. Has the name of the Business ever been changed? Yes ☐ No ☐
3. Has any other establishment amalgamated or merged with you? Yes ☐ No ☐
4. Have you purchased any other establishment? Yes ☐ No ☐

If you have answered yes to 3, 4 or 5, please supply details:

QBE INSURANCE

5. Please list the professional bodies or associations to which the Business belongs

6. Please provide the approximate division of your patients between:

Patients		Percentage
(a)	General/Medical	%
(b)	Oncology	%
(c)	Obstetrics/Maternity	%
(d)	Mental Health	%
(e)	Surgical	%
(f)	Senile or Aged	%
(g)	Paediatric	%
		%
		100%

7. Please provide details of any Radioactive or X-Ray procedures used in diagnosis or treatment

8. Is there any other information in your possession that you would consider material to the risk being proposed? Yes ☐ No ☐

If Yes, please provide full details

DECLARATION

I declare that all answers and statements in this supplementary questionnaire are correct and complete in every respect and there is no further information, outside of that supplied in this questionnaire or the Proposal Form, which may affect acceptance of this proposal.

Signed		Date	/ /
Printed name			
Position			

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