



# HOSPITALS 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 supply the following details

Title of staff member	Name	Age	Qualifications	Date qualified
CEO/General Manager				
Director, Medical Services				
Director, Allied Health Services				
Director of Nursing				

2 Please provide the number of employees in each of the following classifications:

Employee Class	No.	Employee Class	No.
Surgeons		Pharmacists	
Doctors		Registered Nurses	
Interns		Enrolled Nurses	
X-ray technicians		Undergraduate or student staff	
Laboratory technicians		Other medical or allied health employees	

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 Malpractice Liability Insurance? Yes  No

**B BUSINESS DETAILS**

- 1 (a) Has the name of the Business ever been changed? Yes  No
- (b) Has any other establishment amalgamated or merged with you? Yes  No
- (c) Have you purchased any other establishment? Yes  No

If Yes to any of the above, please provide details



2 Please list the professional bodies or associations to which the Business belongs

Empty text box for professional bodies or associations.

3 Does the Business have:

- (a) an intensive care unit? Yes  No
- (b) a casualty or outpatients department? Yes  No
- (c) a radiotherapy unit? Yes  No
- (d) a medical teaching facility? Yes  No

4 Does the Business operate any training school? Yes  No

If Yes, provide full details

Empty text box for training school details.

5 Please provide details of radio-active or x-ray procedures used in diagnosis or treatment

Empty text box for radio-active or x-ray procedures.

6 Please provide details of any clinical trials that have been or are currently being undertaken

Empty text box for clinical trials details.

7 Please provide the approximate division of your patients between:

Patients	%	Patients	%
General/Medical	%	Alcohol & other drugs	%
Surgical	%	Obstetrics/Maternity	%
Oncology	%	Neo-natal	%
Tubercular/Communicable	%	Elective Cosmetic	%
AIDS/HIV	%	Elective terminations	%
Senile or aged	%	Paediatric	%
Palliative	%	Allied health therapy	%
Mental Health	%	<input type="text"/>	%
		<b>TOTAL</b>	<b>100%</b>



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

Empty table with 6 rows for providing 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 [input box]

Date [input box with slashes]

Printed name [input box]

Position [input box]



Quay Tower, 29 Customs Street, PO Box 44, Auckland. www.qbe.co.nz Phone: 00 64 9 366 9920, Fax: 00 64 9 366 9930

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