



PRIVATE CARE FACILITIES SUPPLEMENTARY QUESTIONNAIRE

IMPORTANT NOTICE

This supplementary questionnaire will form a key part of your ongoing contract(s) of insurance with QBE Insurance (International) Limited 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 the number of employees in each of the following classifications.

Employee Class	No.	Employee Class	No.
Doctors		Registered Nurses	
Dentists		Undergraduate or student staff	
X-ray technicians		Other medical or allied health employees	
Pharmacists		TOTAL	

2 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.



3 Please provide the approximate division of your patients between:

Patients	%	Patients	%
General/Medical	%	Surgical	%
Onocology	%	Senile or aged	%
Mental Health	%		%
			100%

4 Please provide details of any radioactive or X-ray procedures used in diagnosis or treatment.

5 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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