GLENRAND M·I·B
RISK SERVICES

GLENRAND M.I.B MEDICAL MALPRACTICE/ PROFESSIONAL INDEMNITY APPLICATION FORM FOR ALLIED HEALTH PROFESSION OR NON MEDICAL PRACTITIONERS

Claims Made

Annual renewable professional indemnity policies are underwritten on a "Claims made" basis. This means that:-

1. In order for a claim to qualify for indemnity a policy must be in force when the claim is first made against the insured. (In terms of the policy conditions you are obliged to notify insurers as soon as you become aware of any circumstances which may lead to a claim. Any actual claim which then materialises would be deemed to be a claim under the policy which was in force at the time when the circumstance was first notified).

2. The cause of action giving rise to the claim must have taken place on or after the 'retroactive date' shown on the certificate of insurance.

3. If the policy has lapsed there will be no cover withstanding the fact that the policy may have been in force at the time when the cause of action arose giving rise to the claim. It is therefore important to renew the policy annually in this regard, however please note the contents of the attached document reflecting the 5 years' free run-off cover and the facility to purchase continuous run-off cover.

Retroactive Date

Claims first made against the insured arising from work performed on or after the retroactive date as it appears on the schedule of insurance will be indemnified in terms of the policy. This date is normally fixed as being the date on which the cover was first taken and would remain unaltered for the purposes of subsequent renewals. When cover is first taken, additional retroactive cover may be offered by insurers subject to certain conditions and premium loadings. Should you be uncertain about whether or not you require retroactive cover, please contact us so that we can assist you.

Non – Cancellable Annual Policy

This policy is an annual policy and does not contain a bilateral cancellation condition.

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GLENRAND M.I.B MEDICAL/DENTAL MALPRACTICE/ PROFESSIONAL INDEMNITY APPLICATION FORM

1. Full Names		1a. Title	1b. Registration number e.g. HPCSA/SAMDC
2a. Postal/Physical address	2b. Tel No.	2c. Fax No.	2d. E-mail 2e. Vat Registration number
3. Date of Birth	4. Qualification	4a. Place obtained 4b. Date obtained	

5. Please identify your principal activity:

6. Previous continuous and unbroken Insurance History (*Please attach supporting documentation e.g. your latest Certificate. We require this information for purposes of assessing your date of retroactive cover):*

6a. Period of Insurance From: To:

6b. Name of Insurer

7. Do you require Retro-active cover: ☐ Yes ☐ No

8. Please state what entity you require cover for, e.g. sole practice, partnership, Clinic etc and provide the facility name or if employed please give the name of employer/facility.

9. Claims or disciplinary experience

a. Has any claim been made against you or your partner? ☐ Yes ☐ No

b. Are you aware after enquiry of any circumstances which may be likely to give rise to a claim? ☐ Yes ☐ No

c. Have you ever appeared before a disciplinary hearing, been found guilty and struck from the role or suspended? ☐ Yes ☐ No

If the answer to any of the above is yes please give full details on a separate sheet of paper.

10. Inception of this policy	11. How did you find out about our medical malpractice product? ☐ Colleague ☐ Journal ☐ Media ☐ Presentation ☐ Conference Any other.....

DECLARATION MUST BE SIGNED BY THE PROPOSER ONLY

I declare that the statements and particulars on this proposal are true and that I have not mis-stated or suppressed any material fact. I agree that this proposal, together with any other information supplied by me shall form the basis of any Contract of Insurance effected thereon. I undertake to inform Insurers of any material alteration to these facts occurring before completion of the Contract of Insurance, or during the subsistence of such contract. No indemnity will be provided in respect of claims or circumstances likely to give rise to a claim as notified in the application form.

Dated this day of 20

Signed Print name in full:

GLENRAND M·I·B
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FAX COVER SHEET

FAX TO:	Professional Services
COMPANY/ FIRMA:	Glenrand MIB
FOR ATTENSION / VIR AANDAG:	Carol-Lee Axford
FAX NO / FAKS NR:	086 639 2614/011 329 1921
DATE / DATUM:	_____
NO. OF PAGES / AANTAL BLADSYE:	_____
FROM / VAN:	_____
TEL NO/	_____

NOTES:

CONTACT: CAROL LEE AXFORD
TEL NO: (011) 329- 1913/1490

E-MAIL: claxford@glenrandmib.co.za