



**FNB**  
First National Bank



**Medical Malpractice / Professional Indemnity Proposal Form**  
**For PsySSA Members**

Name of Insured: \_\_\_\_\_

Identity Number: \_\_\_\_\_

Year Qualified: \_\_\_\_\_ Qualification: \_\_\_\_\_

University attended: \_\_\_\_\_

Any Post-Graduate Qualifications: \_\_\_\_\_

Are you a paid up member of PsySSA, if so, please indicate your PsySSA Number: \_\_\_\_\_

If you belong to any other Body/ies, please indicate which ones \_\_\_\_\_

Which fields of Psychology do you specialize in? \_\_\_\_\_

How long have you been Practicing in your current Profession? \_\_\_\_\_

Has there ever been any conditions to, or revocation of, your membership?  Yes  No

Are you a registered practitioner in terms of HPCSA legislative requirements?  Yes  No (Number \_\_\_\_\_)

Postal Address \_\_\_\_\_

Telephone & Fax Numbers Business \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Business Address \_\_\_\_\_

Limit of Indemnity required:  R2,500,000  R3,000,000  R5,000,000

Do you wish to purchase Public Liability for the equivalent of the Limit selected above? :  Yes  No

Inception date of cover  2017



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**PsySSA**  
Psychological Society  
of South Africa



Are You in private practice:  Yes  No    Are you employed by the Government:  Yes  No

Sole Practitioner?  Yes  No    Partnership  Yes  No

Current Employers (Practice name/Province): \_\_\_\_\_

If State employed, Hospitals Currently Working in: \_\_\_\_\_

What is your gross annual income from private practice (approximately): \_\_\_\_\_

What is your gross annual income from state practice (approximately): \_\_\_\_\_

Have you had previous Medical Malpractice / Professional Indemnity Insurance?  Yes  No

Name of Previous Insurer: \_\_\_\_\_

The Insurance Period: \_\_\_\_\_

The Limits of Indemnity: \_\_\_\_\_

Has any application for this insurance ever been declined?:  Yes  No

Have you ever had this insurance cancelled by the insurer?:  Yes  No

Have you ever required special terms on this kind of insurance?:  Yes  No

If yes to any of above please give details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any claims made against you, for the insurance now proposed in the past five (5) years?  Yes  No

If 'Yes' please provide details:

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the allegations and the details of Claimant



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Are you aware of any circumstance / complaints which may give rise to a claim being made against you?  Yes  No

If "Yes" please provide details:

Date of Circumstance / Complaint	Details including nature of the complaint and details of the complainant

Have all known claims and circumstances / complaints been notified to your previous insurers?  Yes  No  N/A

Have all known claims and circumstances / complaints been accepted by your previous insurers?  Yes  No  N/A

**Declaration**

I/We declare that to the best of my/our knowledge and belief the answers given on this form, documents or papers submitted, represent the true position and that I/we have not withheld any information material to this application. I/We agree that this application and accompanying documents or papers shall form or partly form the basis of the Contract proposed. I/We have read and understood the Duty of Disclosure notices.

Signature of Applicant: \_\_\_\_\_

Position: \_\_\_\_\_

Date: \_\_\_\_\_