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 ____

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Telephone & Fax Numbers Business ____________________ Cell ____________________

Email Address ____

Business Address ____

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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 [   ] 2019

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:

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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**

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, the undersigned, declare that the statements set forth in this proposal form together with any other information supplied are true and correct and that I/we have not misstated or suppressed any material facts.
I/We agree that this proposal form together with any other information supplied by me/us shall form the basis upon which the contract of insurance is concluded and shall be incorporated therein.
I/We further undertake that in the event that the information provided changes between the date of this application and inception of cover, I/We will notify FNB / iTOO of such changes as soon as reasonably possible.

Signature of Applicant: ____

Position: ______________________ Date: ______________________