Avant *Practitioner* Indemnity Insurance Policy Application form

Practitioner Indemnity Policy with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765
Effective: December 2023.

This is an application form for Membership and a Practitioner Indemnity Insurance Policy. It is a legal document which will form (a) the basis of the contract of insurance between the insured (you) and Avant Insurance Limited (Avant Insurance); and (b) the basis of your contract of Membership with Avant Mutual Group Limited (Avant). When reading this document a reference to 'we', 'our' and 'us' will mean Avant Insurance. 'You' and 'your' will mean the insured.

Your duty of disclosure: Before you enter into an insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms. You have this duty until we agree to insure you. You have the same duty before you renew, extend, vary or reinstate an insurance contract. You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay you if you make a claim, or both. If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed. Please read the Practitioner Indemnity Insurance Policy, complete this form, and accept the declarations. You can find the Practitioner Indemnity Insurance Policy wording online at **avant.org.au**. Please contact us on **1800 128 268** with any questions.

1. Your details

Title		First name		Last name	
Gender*	☐ Male ☐ Female	Date of birth		Mobile	

*Supporting our gender diverse community. We are currently reviewing our gender and sex at birth options to ensure our products and services provide appropriate terminology and selections in line with the diversity of our community.

Email		Work telephone	
Alternate email			
Residential address			
Primary practice address			
Preferred mailing address	☐ Residential ☐ Practice		

2. Qualification and registration information Please list your medical qualifications

a) Medical qualifications

Qualification		Qualification	
University/ institution		University/institution	
Year awarded		Year awarded	
Country		Country	

b) Do you require a temporary visa to work in Australia? If **YES** please attach a copy. ☐ Yes ☐ No

c) Please provide your Ahpra registration details		Registration number	

d) Has your registration to practice as a healthcare practitioner ever been refused, revoked, suspended or had conditions applied to it or has there ever been a matter brought before a registration board? If **YES**, please provide details in the 'additional information' section or on a separate page. ☐ Yes ☐ No

3. Medical practice information

a) What is your category of practice? Please refer to the Category of Practice Guide to identify the category that covers the healthcare you provide.

b) Do you hold a public appointment? ☐ Yes ☐ No

c) Do you require cover for the treatment of public patients where you are **NOT** entitled to indemnity from any other source (including but not limited to a state government, hospital or area health service, another person or your employer)? ☐ Yes ☐ No

If **YES**, please provide details about the workplace where you will be treating public patients in the 'additional information' section or on a separate page and provide your estimated annualised gross income for public practice below.

d) Please provide your estimated annualised gross billings* for the next 12 months:

*Please read the definition of gross billings in the Category of Practice Guide. You must provide an accurate estimate of your annual gross billings otherwise you may not be covered in the event of a claim against you.

Private practice	$
Public practice income **(only complete if YES above)**	$

e) Do you perform any cosmetic procedures? I.e. procedures for which there is no Medicare item number assigned, or for which a Medicare item number is assigned but it not claimable? ☐ Yes ☐ No

If **YES**, please provide details in the 'additional information' section or on a separate page.

f) Do you provide any healthcare which would not normally fall within the scope of your specialty or field of practice? ☐ Yes ☐ No

If **YES**, please provide details in the 'additional information' section or on a separate page.

g) In the last 5 years have you: ☐ Yes ☐ No
   i. changed your category of practice
   ii. changed your billings by more than 50%
   iii. changed your location
   iv. practiced under a different name

If **YES**, please provide details, including year, specialty, annual billings and/or location in the 'additional information' section or on a separate page.

4. Past claims, incidents and registration

If **YES** to any of the below, please provide details in the 'additional information' section or on a separate page.

a) Have you or a practice in which you work or worked: ☐ Yes ☐ No
   i. ever been subject to an investigation, complaint, inquiry (including Medicare inquiry), audit, coronial inquest or proceeding; or
   ii. ever been involved in any claims, demands, suits or other legal actions; or
   iii. ever been counselled, disciplined or had authorisations altered by an employer, a hospital, an area health authority, a medical college, a statutory body or a medical board in relation to your conduct as a healthcare professional.

b) Are you: ☐ Yes ☐ No
   i. aware of any act, error, omission or circumstance in respect of your conduct as a healthcare professional; or
   ii. aware of any matter or potential matter, including any potential defamation dispute, employer or employee dispute or audit by the Australian Tax Office that was or could have been notified under any insurance policy that was or is in force prior to the inception of this policy?

c) Have you: ☐ Yes ☐ No
   i. ever been diagnosed with or treated for cognitive impairment or any other health conditions that may affect your performance as a healthcare professional; or
   ii. ever been charged with, convicted or found guilty of a criminal offence in any country; or
   iii. ever made a self notification or been the subject of a voluntary notification to Ahpra?

5. Past insurance and medical indemnity details

a) Have you ever been indemnified by an Australian medical defence organisation or insurance company in the past? ☐ Yes ☐ No

If **YES**, please provide details:

Insurer					
Start date		End date		Retroactive date	
Insurer					
Start date		End date		Retroactive date	

b) Have you: ☐ Yes ☐ No

i. ever had an application or renewal for professional insurance refused; or
ii. had a loading, deductible or special condition placed on your insurance; or
iii. been offered or provided with a reduced level of cover; or
iv. had your application declined; or
v. had your policy cancelled?

If **YES**, please provide details in the 'additional information' section or on a separate page.

c) Have you ever worked in the public sector where you have **NOT** been entitled to indemnity from any other source (including but not limited to a state government, hospital or area health service, another person or your employer)? ☐ Yes ☐ No

If **YES**, please provide details about the workplace where you were treating public patients in the 'additional information' section or on a separate page and provide your estimated income for that period of public practice.

6. Policy details

a) If your application is approved, your cover will start from the date we approve your application unless you would like a future date. If so please specify.

When would you like this policy to end? ☐ 30 June ☐ 31 December

b) Retroactive cover or cover for your past practice is the protection for the healthcare you provided after your retroactive cover date and before the start date of your current medical indemnity insurance policy. This can be the date that you became registered in Australia or your retroactive date with your current insurer.

Please nominate a retroactive date.

c) Do you require additional retroactive cover because: ☐ Yes ☐ No

i. you were not covered by an insurance policy in the past; or
ii. you returned to private practice after a period of no private practice; or
iii. you previously changed insurer and did not take out run off cover?

For more information visit **avant.org.au/retroactive-cover**

If **YES**, please provide details:

Date from		Date to	
Date from		Date to	

d) Do you want to participate in the Premium Support Scheme? ☐ Yes ☐ No

If **YES**, we will send you Premium Support Scheme terms and conditions and Premium Support Scheme request form. Please refer to the terms and conditions for details of the eligibility criteria. You can access the booklet online at **avant.org.au** or by requesting a copy from **Member Services** on **1800 128 268**.

e) Do you wish to apply for personal expenses optional cover and interruption to earnings optional cover?

For more information about this option and what this covers you for, please refer to Part C of the Avant Practitioner Indemnity Insurance Policy. ☐ Yes ☐ No

Electronic communications disclosure and consent

You will receive the product disclosure statement, renewal documentation, Financial Report and Annual Report electronically. If you wish to receive these by post, please email us at **memberservices@avant.org.au**.

I consent to Avant contacting me in accordance with Avant's Privacy Policy (including via email and SMS if you have provided your email address and mobile number). I understand that I may alter this consent at any time by contacting Avant.

You will receive the notice of Annual General Meeting and other member communications from Avant electronically to the email address you have nominated. If you wish to receive these by post, please contact us at **memberservices@avant.org.au**.

Please ensure that you maintain a current email address with us at all times so that we can ensure the successful delivery of communications to you. If you change address, change practice details or move overseas please let us know.

7. Application and declaration

I hereby apply for membership of Avant and for a Practitioner Indemnity Insurance Policy from Avant Insurance. I agree to be bound by the Constitution of Avant and the terms of any insurance issued to me by Avant insurance. I declare that by signing, typing my name, or entering an electronic signature in the space provided and returning this form that:

a) the information I have given in this application form and in any accompanying documents is true and correct, and I understand that Avant Insurance will rely on this information in deciding whether to provide me with an insurance contract and on what terms and conditions, and that it will form the basis of my policy

b) the retroactive date I have selected is adequate to cover me for all prior uncovered incidents and I agree to accept all future offers of retroactive cover as set out in the Policy and this application form, unless I otherwise advise Avant Insurance in writing. If I decide not to accept any offer of retroactive cover or future offers of retroactive cover, I may be uninsured for incidents occurring prior to the commencement date of my policy

c) if I have asked for public patient cover I understand that I need to determine if I am entitled to cover for civil liability for public patients from a hospital, area health service, a government scheme, or another person and that cover for civil liability will only be provided to me where I have no right to indemnity

d) I understand my duty of disclosure exists until the contract of insurance is entered into and that I have a continuing obligation to inform Avant Insurance of any material alteration of the risk during the policy period – including any change in the nature or location of my practice or my billings (if any)

e) I have read and understood the Product Disclosure Statement, Practitioner Indemnity Insurance Policy, Category of Practice Guide and Constitution of Avant and I acknowledge that cover is subject to the terms, conditions and exclusions of the Policy

f) I understand this application is subject to approval by Avant and Avant Insurance. I acknowledge that if a contract of insurance is issued it will be subject to the terms and conditions of the policy provided to me or as otherwise specifically varied by Avant Insurance and agreed to by me

g) I authorise Avant Insurance to discuss and obtain information or documents in relation to insurance matters or claims history from another insurance company, MDO or an insurance reference bureau or similar organisation

h) I authorise Avant Insurance to obtain information and documents in relation to my registration, conditions of my registration or any other matter from any Medical Board or other registration body

i) I understand I may be required to participate in an audit to verify my category of practice and/or my gross private practice billings (if any) and that I must cooperate and facilitate such an audit. This may include the provision of a Statutory Declaration by me with regard to my gross billings for private practice.

Print name			
Signature		Date	

Please return this form to **Avant Insurance Limited, PO BOX 746 Queen Victoria Building NSW 1230**, or **email applications@avant.org.au** or contact us on **1800 128 268**.

8. Additional information	
Section number	Additional details

Notes