Practice Medical Indemnity Policy Application form

Practice Medical Indemnity Policy with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765
Effective: November 2023

This is an application form for a Practice Medical Indemnity Policy. This is a legal document, which will form the basis of the contract of insurance between the legal entity applying for insurance cover ('you' or 'your') and Avant Insurance Limited ('we', 'our', 'us' or 'Avant Insurance').

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 Practice Medical Indemnity Policy wording, complete this form, and accept the declarations. You can find the Practice Medical Indemnity Policy wording online at **avant.org.au**. Please contact us on **1800 128 268** with any questions.

Practice details

1. Name and ABN/ACN of principal business to be insured (e.g. parent company or trustee)	
Incorporated name of principal business to be insured	
Trading name	
ABN/ACN	
Practice website	

2. Is the business

- ☐ Sole trader
- ☐ Partnership
- ☐ Trust structure entity
- ☐ Private company
- ☐ Listed public company
- ☐ Unlisted public company
- ☐ Subsidiary of a company
- ☐ Not for profit (non-exempt from stamp duty)
- ☐ Not for profit (exempt from stamp duty, certificate required)
- ☐ Other _____

Important notice

The definition of insured automatically includes companies that are subsidiaries of the principal business. To make certain that all of your heathcare services are covered please ensure your answer at Question 9, heathcare services, includes all of the activities of your business. If you are seeking cover for multiple businesses please include them as a principal insured at Question 1.

3. Date the principal business was established	

4. Address and contact details of principal office			
Address		Phone number	
		Email	

5. Do you operate from more than one location? ☐ Yes ☐ No

If **YES**, please provide details.

Agent and authorised representative

6 a) Please complete details for the primary authorised contact person e.g. practice manager or director. This person will have authority to liaise with Avant Insurance and can make changes to the policy.

Name		Title		Position	
Email		Mobile			
DOB		Password			

b) Please specify any other practice staff that you would like to have access for enquiry only.

Name		Title		Position	
Email		Mobile			
DOB		Password			
Name		Title		Position	
Email		Mobile			
DOB		Password			

Healthcare services

7. Your policy covers you for the healthcare services that you disclose to Avant. Please provide a full description of the healthcare services that are to be covered and type of medical practice. Please ensure that you disclose all services provided, or that you are intending to provide during the next 12 months, otherwise you may not be fully covered.

Type of medical practice	
Services provided	

8. Financial activity of the practice. The gross billings and annual revenue of your practice provides us with an indication of the volume of healthcare services provided by your practice and the exposure your practice has to claims. They must be as accurate as possible otherwise you may not be fully covered.

All healthcare services gross billings		Annual revenue	
Next financial year (estimate)	$	Next financial year (estimate)	$
Current financial year	$	Current financial year	$
Actual last financial year	$	Actual last financial year	$

9. Please advise percentage of annual revenue by state or territory below.
Note if you require cover for overseas, please attach a separate sheet providing details of the services.

NSW	VIC	QLD	ACT	WA	SA	NT	TAS

10. Does the practice undertake any of the following services?

Day surgery	☐ Yes ☐ No	If **YES**, number of outpatients		Number of overnight beds
Obstetrics services (shared antenatal services excluded)	☐ Yes ☐ No	If **YES**, percentage of annual turnover from this activity		
Cosmetic services	☐ Yes ☐ No	If **YES**, percentage of annual turnover from this activity		
Anaesthetic services	☐ Yes ☐ No			
Clinical trials	☐ Yes ☐ No			
Termination of pregnancy	☐ Yes ☐ No			

If **YES**, please provide details.	

11. Is the practice participating in any joint ventures? ☐ Yes ☐ No

If **YES**, please attach details separately.

12. Has the practice conducted other healthcare services in the past, which have not been described above for which you require cover for? ☐ Yes ☐ No

If **YES**, please provide details.

13. Does the practice perform activities or provide services outside of Australia which you require cover for? ☐ Yes ☐ No

If **YES**, please provide details.

14. Does the practice provide a referral service or any computer/IT services to other healthcare providers? ☐ Yes ☐ No

If **YES**, please provide details.

15. Is the practice required to be accredited or licenced in order to provide the healthcare services that cover is being requested for? ☐ Yes ☐ No

16. Has the practice been formally accredited in the past 12 months (AGPAL, GPA, Medicare Local, ISO, APA etc.)?

If **NO**, please attach more information separately as to what formal risk management framework and/or accreditation regime you operate under. ☐ Yes ☐ No

Details of persons engaged in the business

17. Does the practice employ a full time practice manager? ☐ Yes ☐ No

If **YES**, please provide name of practice manager and any relevant qualifications.

18. Please provide details of allied healthcare professionals and other healthcare professionals (other than medical practitioners, including technicians) engaged in the business. Attach a separate page if more space is required.

Name	Category of practice	Status (director, employee, contractor, room rental)	Insurer

Details of persons engaged in the business

19. Does the practice check at commencement and annually that each medical practitioner or contractor providing healthcare services

Holds appropriate medical/professional indemnity insurance?	☐ Yes	☐ No
Is registered to provide the services that they provide?	☐ Yes	☐ No
Is appropriately qualified for the duties they undertake?	☐ Yes	☐ No

20. Do any practice staff provide healthcare services to patients without supervision of a medical practitioner? ☐ Yes ☐ No

If **YES**, please provide details.

21. Please provide details of medical practitioners engaged in the business (note that medical practitioners must hold their own professional indemnity insurance cover). Attach a separate page if more space is required.

Title	Name	Category of practice	Status (director, employee, contractor, room rental)	Avant member ID or name of other Insurer

22. Please complete the table below:

Staff type	# Employees (include part time and casual)	# Contractors	Room rental
Nurse			☐ Yes ☐ No
Nurse practitioner			☐ Yes ☐ No
Midwife (non-intrapartum)			☐ Yes ☐ No
Midwife (intrapartum)			☐ Yes ☐ No
Technician			☐ Yes ☐ No
Beautician			☐ Yes ☐ No
Administration staff			☐ Yes ☐ No
Management staff			☐ Yes ☐ No
Total			

23. Are there any directors, employees, contractors who are registered health professionals that have conditions, limitations, or undertakings on their registration? ☐ Yes ☐ No

If **YES**, please provide details.

24. Do you have written policies and/or procedures in place to cover the practice for employee terminations, harassment, anti-discrimination and equal opportunity issues that may arise? ☐ Yes ☐ No

If **NO**, please provide details of how human resources issues are managed by the practice.

Claims and insurance history

25 a) Have any medical indemnity claims been made against the practice during the last 10 years? ☐ Yes ☐ No

If **YES**, please provide details.

Date of incident	Date of claim	Details of matter	Amount paid	Amount outstanding

25. b) After investigation with the employees, medical practitioners and anyone else engaged in the business, are you aware of any incidents or events which may lead to a claim or matter that could be covered by this policy? ☐ Yes ☐ No

26. Has the practice held professional indemnity insurance in the past? ☐ Yes ☐ No

If **YES**, please provide details.

Insurer	Policy period	Limit of indemnity	Deductible	Retroactive date

27. Has the practice ever had an application or renewal for professional indemnity refused, a loading or special condition placed on insurance, or been offered or provided with a reduced level of cover? ☐ Yes ☐ No

If **YES**, please provide details.

Insurer	Details of declinature, cancellation or special terms

Insurance requirements

28. What date do you wish the policy to commence?
Please note: If we approve your application and you then accept our offer of insurance, the insurance cover will start from the date we approve your application unless you request a later start date.

29. Please identify the limit of practice indemnity you require. If you require a higher limit than those listed below please contact us.

☐ $5,000,000 ☐ $10,000,000 ☐ $20,000,000

30. Does the practice require retroactive cover? ☐ Yes ☐ No

If **YES**, what date do you want the retroactive cover to start from?

31. Does the practice require the following optional extensions (an additional premium will apply)?

Reinstatement (x1)? ☐ Yes ☐ No

Legal defence costs in addition to the limit of indemnity? ☐ Yes ☐ No

Public liability? ☐ Yes ☐ No

If **YES**, please complete addendum.

Public liability optional cover – addendum

Only complete this addendum if you require public liability cover. The limit of public liability offered is $20,000,000.

1. Please provide the following details of the buildings that are used by you

Building address	Age	Levels	Owner/leased

2. Are you currently located within another company's public or private healthcare facility, including hospitals, day surgeries and where your reception area is located? ☐ Yes ☐ No

If **YES**, please provide details.

3. Do you sub-contract out to other parties any functions of your business? ☐ Yes ☐ No

If **YES**, please provide details.

4. Do you ensure that all sub-contractors have current liability insurance in place? ☐ Yes ☐ No

5. Do all premises comply with fire and evacuation procedures? ☐ Yes ☐ No

6. Please describe the fire protection and prevention procedures in place

7. Do all premises comply with applicable laws of the Commonwealth and/or states or territories they are located within in relation to the following?

Disposal of sharps	☐ Yes ☐ No
Disposal of hazardous waste	☐ Yes ☐ No
Sterilisation of equipment	☐ Yes ☐ No

8. Do you perform any offsite activities (for example car parking, patient transport etc.)? ☐ Yes ☐ No

If **YES**, please provide details.

9. Is there a written corporate policy which outlines the objectives and constraints of emission, waste and effluent management? ☐ Yes ☐ No

10. Has the practice held public liability insurance in the past? If **YES**, please provide details. ☐ Yes ☐ No

Insurer	Policy period	Limit of indemnity	Deductible	Occurrence or claims made policy? (if claims made what is the retroactive date?)

11. Has the practice ever had an application or renewal for public liability refused, a loading or special condition placed on insurance, or been offered or provided with a reduced level of cover? If **YES**, please provide details. ☐ Yes ☐ No

Insurer	Details of declinature, cancellation or special terms

IT Information

Does your practice engage an IT service provider?			☐ Yes	☐ No
Does your practice have multi-factor authentication in place for all remote user access to the practice?	☐ Email only	☐ Email and network	☐ Network only	☐ No
Does your practice have backups held offline from your network or in a cloud service designed specifically to be used for this purpose?			☐ Yes	☐ No
Do you utilise anti-virus software on all network endpoints, servers and access points?			☐ Yes	☐ No

Electronic communications disclosure and consent

You will receive the policy wording and renewal documentation 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.

Consent and declaration

Before signing the declarations, please review the information you have provided and ensure that you have answered all sections accurately and to the best of your knowledge and belief. You must also read the policy wording before signing the declarations.

NSW stamp duty exemption declaration

If your practice is in NSW and you meet certain criteria, you may be eligible for stamp duty exemption on your practice insurance premium. I declare that:

I am a small business owner within the meaning of Section 152-10 (1AA) of the *ITAA 1997* of the Commonwealth for the income year in which the insurance is effected or renewed.	☐ Yes	☐ No
I am carrying on a business with a turnover of less than $2 million in the last financial year.	☐ Yes	☐ No
I will undertake to inform you if my small business status changes in the future, i.e. if my turnover exceeds $2 million per annum.	☐ Yes	☐ No

Declaration of information

This declaration must be completed by either a director, chief executive officer, chief financial officer, practice manager or duly authorised person of the practice.

I declare that:

a) I am duly authorised by the company to sign this proposal form on its behalf.

b) The information I have given in this application form and in any additional pages is true and correct, and I understand that Avant Insurance will rely on this information in deciding whether to provide the practice with an insurance contract and on what terms and conditions, and that it will form the basis of the policy.

c) I understand I have a duty under the *Insurance Contracts Act 1984* that means that before I enter into this Policy the practice must disclose to Avant Insurance every matter that the practice knows, or could reasonably be expected to know, that is relevant to Avant Insurance's decision to accept the Policy and, if so, on what terms and if the practice fails to comply with that duty Avant Insurance may refuse or reduce its liability for a claim or cancel the Policy. Full details of the duty of disclosure are set out in the policy wording. I have read and understood the Practice Medical Indemnity Policy wording. I acknowledge that if a contract of insurance is issued it will be subject to the terms and conditions of the policy wording provided to the practice or as otherwise specifically varied by Avant Insurance and agreed to by a duly authorised person of the practice.

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

Signature		Please tick ☐ Director ☐ CFO ☐ CEO ☐ Practice manager	
Print name		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**.

Additional information		
Section name	Section number	Additional details