ECONET Insurance (PVT) Ltd

INSTITUTIONS PROPOSAL FORM

THIS QUESTIONNAIRE IS SUBMITTED TO ECONET INSURANCE PRIVATE LIMITED FOR THE PURPOSE OF ARRANGING A BONDING FACILITY.

Please answer **ALL** questions completely
Should any question or part thereof not be applicable, please state "N/A"
Should insufficient space be provided, please continue on your company letterhead

It is advisable to insure independently operating branches or subsidiary companies which are removed from the direct control of head office under a separate policy

1. Name of Insured ____

2. Has the Insured ever carried out medical services under a different name

Yes		No	

If ***YES***, please provide details

3. Head office physical and postal address ____

____

4. Location of branch offices ____

5. Telephone Number ____

6. Email Address ____

7. Does the Insured have any subsidiary companies that you require cover for

Yes		No	

If ***YES***, please provide details

8. VAT Number ____

9. Registration Number ____

10. Please give a full description of the Insured's business activities for which cover is required

11. Revenue

a. When is your financial year end

b. What are your estimated fees for the coming 12 months

c. Please provide gross revenue (VAT Inclusive) received

Gross Revenue	Last Financial Year End	Previous Financial Year End
Hospital/Clinic		
Rentals/Leases		
Medical procedures/Treatments		
Pharmacies		
Any other source		
Total		

12. Please state the owner(s) names and details of their experience and qualifications

Name	Shareholding (%)	Experience/Qualifications

13. Does the Insureds activities involve a joint venture with any other company, partnership, individual or other professional grouping

Yes		No	

If ***YES***, please provide details

14. Will the Insureds activities involve new or incoming partners that are involved in your activities during the next 12 months

Yes		No	

If ***YES***, please provide details

15. Are public funds or private funds or endowments used to maintain the Insured, either in whole or in part

Yes		No	

If ***YES***, please state percentage

16. Are any beds or services available to the community on a charitable basis

Yes		No	

If ***YES***, please state percentage

17. Please state number of beds maintained

a. Full pay beds or part-pay beds (other than bassinets for maternity cases)	
b. Charity beds (other than bassinets)	
c. Maternity beds (i.e. bassinets)	

18. Number of babies delivered on an annual basis

a. Does the Insured have a neo-natal ward	
b. Number of bassinets/cribs	
c. Ratio of nurses to babies	

19. Number of operating theatres

20. Average annual bed occupancy. (Calculate by noting the occupancy at any specific day of each month and dividing the aggregate total of 12 months by 12.)

21. Please state the approximate division of your patients between

Major Surgery		ENT	
Minor Surgery		Dental/Maxillofacial	
Cosmetic Surgery		Accident & Emergency	
Orthopaedics		Drug/Alcoholic	
Obstetrics/Gynaecology		Communicable Infectious Diseases	
Paediatric		Frail Care/Aged	
Ophthalmology		Insanity/Psychiatric	
Prosthetic Fitment		Other	
Other			

22. In respect of medical services at the address specified above, are you in possession of the registered licenses and or registrations from the applicable regulatory body, or as required by law

Yes		No	

If ***NO***, please provide details

23. Which associations, professional bodies or self-regulatory organisations is the Insured a member of or registered with

24. Is the Insured a member of a group of hospitals

Yes		No	

If ***YES***, please provide details

25. Is the Insured affiliated to any other medical interest

Yes		No	

If ***YES***, please provide details

26. Please state number of X-Ray machines/M.R.I/C.A.T or similar scanners owned or operated, and whether they are used for

a. Diagnosis	
b. Treatment	

27. Does the Insured administer Radium, or any other forms of radio-active treatment

Yes		No	

If ***YES***, please provide details

28. Please state number of employees in each of the following classifications

Staff Compliment	No. of Employees	No. Self-Employed	No. of Years Practising
Anaesthesiology			
Cardiac/Thoracic/Vascular Surgery			
Cardiology			
Dental Surgery/Maxilla-Facial			
Dentist/Orthodontist			
Dermatology			
ENT			
General Practitioner			
General Surgery			
Gynaecologists			
Internal Medicine			
Lab/Pathology Technicians			
Neonatology			
Neurology			
Nurses:			
a. Enrolled Nurses			
b. Matrons			
c. Midwives			
d. Nurse Anaesthetist			
e. Registered Nurses			
f. Student Nurses			
g. Auxiliaries Nurses - Qualified			
Care Workers			
Obstetricians			
Orthopaedic			
Paediatrics			
Paramedics			
Pharmacists			
Plastic Surgery			
Radiology			
Residential Medical Officers			
Urology			
Directors/Partners/Principals			
Administration			
Other:			
Total			

29. Is any telemedicine undertaken by the Insured | Yes | | No | |

If ***YES***, please provide details

30. Do you operate any road or air ambulance services | Yes | | No | |

If ***YES***, please advise if use is for patient transfer or first response, and whether outside of South Africa

Question				
31. Do you use nurse anaesthetists	Yes		No	
32. Do you ensure that they carry individual medical malpractice cover	Yes		No	
33. Do you have a fully qualified anaesthesiologist available on site at all times	Yes		No	
34. Do you have a blood bank	Yes		No	
35. Do you provide fertility treatments/drugs/contraceptives	Yes		No	

36. a) Do you undertake clinical trials, or provide facilities at which clinical trials can be undertaken | Yes | | No | |

If ***YES***, please state all active trials during the last 12 months

b) Are the trials being conducted at your premises approved by the Ministry of Health and Child Care. | Yes | | No | |

c) Have the trials been registered with the Ministry of Health and Child Care. | Yes | | No | |

Do you undertake surgical procedures, including transplants | Yes | | No | |

If ***YES***, please provide details

38. Are accurate and descriptive records of all medical services and procedures kept | Yes | | No | |

39. How are they stored, where and for how long

40. Does the Insured undertake staff training — Yes ☐ No ☐

If ***YES***, please provide details

41. Does the Insured undertake to ensure that trainees carry out their duties under proper supervision — Yes ☐ No ☐

42. Does the Insured maintain Clinics (e.g. Mammograms, Antenatal Clinics, Renal Clinics etc.) — Yes ☐ No ☐

a. Type	
b. Free patients/full pay/part pay	
c. Number of:	
• Clinics	
• Doctors	
• Nurses	
d. Estimated total number of patients per year	
e. Estimated number of foreign patients treated per year	

43. Do your staff receive any formal medical malpractice risk management training — Yes ☐ No ☐

44. Are all buildings owned or used by you in a good state and regularly maintained/repaired — Yes ☐ No ☐

45. Are the following regularly checked, serviced and repaired by fully qualified contractors

a. Air Conditioning Units	Yes		No	
b. Electricity Generators (including any emergency backup generators)	Yes		No	
c. Escalators	Yes		No	
d. Heating Systems and Boilers	Yes		No	
e. Hoists	Yes		No	
f. Incinerators	Yes		No	
g. Lifts	Yes		No	

h. Water Tanks	Yes		No	
i. Sprinkler System	Yes		No	

46. Please provide details of any subcontracted functions or facilities

47. Do you ensure subcontractors carry their own insurance — Yes ☐ No ☐

48. Are there facilities for safe collection, storage and disposal of (in accordance with current guidelines/legislation)

a. Sharps	Yes		No	
b. Dressings, clinical and surgical waste, etc.	Yes		No	

49. Do you ensure that the following are safely disposed of (in accordance with current guidelines/legislation)

a. Blood and blood products	Yes		No	
b. All other medical waste	Yes		No	

GENERAL INFORMATION

50. List all circumstances/complaints/claims of professional negligence, error or omission or public liability that have been made against the Practice or any of the present or past Principals or employees, whether insured or not, in the past 5 years

51. Are any of the Principals or Employees of the Practice, after enquiry, aware of any circumstances that may give rise to a claim for professional negligence, errors or omissions or public liability — Yes ☐ No ☐

If ***YES***, please provide details

52. Has any application for insurance of this nature (made on behalf of the Practice or their predecessors in business or by any of the present Partners) ever been declined, cancelled or has renewal been refused or have special terms been imposed — Yes ☐ No ☐

If ***YES***, please provide details

LIMIT OF INDEMNITY

QUOTE REQUEST	

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 Econet Insurance (Pvt) Ltd of such changes as soon as reasonably possible.

Name (duly authorised) ____________________

Designation ____________________

Signature ____________________

Date D D M M Y Y Y Y