PROPOSAL FORM
ACCU-PROF NURSES & CARE WORKERS

Please answer **ALL** questions in full.
Should any question or part thereof not be applicable, please state "N/A".
Should insufficient space be provided, please continue on a separate page.

The completion of this proposal does not bind the proposer or company to complete a contract of insurance.

Please state your title, full first name[s] and surname:

ID / Passport number:

1. Are you currently a member of any Medical Council / SANC / HPCSA? Yes ☐ No ☐

1.1 If **YES**, please provide us with the names of the Licensing / Regulatory Bodies you are registered with?

1.2 Please confirm your relevant Licensing / Regulatory Body registration / membership number:

1.3 Are you a member of any professional organization or registered with any self-regulating body? Yes ☐ No ☐
If **YES**, state which:

Please provide your VAT registration number (if applicable):

Tel:

Physical or Postal address:

E-mail address:

Please state your registered post-graduate qualifications, where and when this was obtained.

2. How long have you been in practice?

3. Please list your registered qualifications and name the medical school you attended:

4. Please indicate your Occupation:

Student Care Worker ☐ Care Worker ☐ Enrolled Nurse ☐
Student Nurse ☐ Auxiliary Nurse ☐ Qualified Nurse ☐

4.1 Specialty field:

4.2 Please indicate the specific specialist area or ward for which you are providing services (Example: ICU, theater, primary Health):

5. If you work at a Hospital, kindly advise whether you provide service as an:

Independent Contractor ☐ Employee of the Hospital ☐ Agency Worker ☐

iTOO Special Risks (Pty) Ltd
Villa Arcadia, 22 Oxford Road, Parktown, Gauteng, 2193 | PO Box 87419, Houghton, 2041 | Tel: 0861 004 866 | Email: info@itoo.co.za | **www.itoo.co.za**

5.1 If an Employee, please give the name of employer / facility:

5.2 If an Independent Contractor, please specify facilities where services are rendered:

6. Do you provide telehealth services as part of your professional nursing practice? Yes ☐ No ☐

If **YES**, please specify the environment in which these services are delivered and provide full details:

7. Is there any additional information that may have significance, when we assess your individual risk, for example full time Hospital employment, academic involvement, registrar, parttime private practice, etc?

8. Please state the earliest date [month and year] of continuous and unbroken indemnity society membership or medical malpractice insurance cover to date of this application. Please attach supporting documentation e.g. your latest certificates. **We require this information for purposes of assessing your date of retroactive cover.**

9. Has any application for insurance of this nature ever been declined, cancelled or has renewal been refused or have special terms been imposed? Yes ☐ No ☐

9.1 Please provide further details regarding declined or cancelled insurance, refused renewal or special terms imposed.

10. Have you had any civil or criminal actions against you, where there was a finding of liability or guilt with respect to your clinical practice? Yes ☐ No ☐

If **YES**, please give a short description about any claims / incidents / circumstances mention above:

11. Does any person involved in the treatment and care of any patient / client suffer from any disability, transmittable diseases i.e. Hepatitis, HIV, etc. or any other impediments which may affect the performance of his / her professional duties or place any patients / clients at risk. Yes ☐ No ☐

If **YES**, provide details:

12. Do you have any physical or mental condition or substance abuse problems that could affect your ability to safely and competently undertake the provision of nursing care? Yes ☐ No ☐

If **YES**, provide details:

13. Please select limit of Indemnity cover to be quoted:

Students	☐ R3 000 000
Care Workers / Auxiliary Nurses	☐ R3 500 000
Nurses	☐ R5 500 000
	☐ R6 500 000
	☐ R10 500 000

14. It is hereby understood and agreed that the Insurer shall not be liable to make any payment for loss in connection with any claim made against the insured arising out of, based upon or attributable to any State work.

☐ **Acknowledged and Accepted**

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This application form is issued and processed by **Accu-Prof Brokers. Accu-Prof** is an authorized financial service provider, registered with the Financial Service Board **[FSP nr. 32066].** All claims have to be submitted to **Accu-Prof** immediately upon learning thereof. For more information on **Accu-Prof** please visit www.accuprof.co.za or phone 012-345 5015. In exchange for brokering services **Accu-Prof** receives commission from the Insurer. The exact is disclosed in the master **Policy Wording** and is available on request.

You have not received individual advice on this product and if there is anything in the application form or about the product that you do not understand, you should contact **Accu-Prof** to assist you. Advice is provided by any party or person other than an accredited **Accu-Prof** representative may not be relied on and **Accu-Prof** does not accept responsibility for advice provided by an unregistered person. You have to ensure that you understand the form, that you complete it correctly and not withhold any information as this may lead to repudiation of claims. You also have to ensure that the product applies to you and that you need it. You should make certain that you can afford the premiums. If quote accepted, you will be issued with a certificate of insurance, which you must study and keep in a safe place.

☐ **I Agree**

The Declaration must be signed by the Proposer only

IMPORTANT: It is necessary for you to inform us of all the facts which are likely to influence us in acceptance or assessment of your indemnity. Failure to do so could invalidate this indemnity. If you are in doubt whether any facts may influence us, you should disclose it.

I declare that to the best of my knowledge or belief, the statements and particulars given in this proposal are true and complete and that no material facts that are likely to influence the acceptance and assessment of this proposal have been withheld. [If you are in any doubt whether a fact is material, you should disclose it].

I agree to inform the insurer of any change in my material fact.

I also declare that if any information on this proposal has been written by another person on my behalf, that, that person acted as my agent for that purpose.

I agree that this proposal and declaration shall be the basis of the contract between myself and the Insurance Company will accept the risk.

☐ **I Agree**

Name and Surname of Proposer [print]: _____

Signature of the Proposer: _____ **Date:** _____

No cover is in force until the Insurance Company has accepted the proposal and the premium paid, except if provided by an official covering note issued by the Insurance Company.

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