

## Important Facts Relating To This Proposal Form

You should read the following advice before proceeding to complete this proposal form.

### Duty of Disclosure

Before you enter into a contract of general insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of insurance, and if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of general insurance.

Your duty, however, does not require disclosure of any matter:

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows or, in the ordinary course of his business, ought to know;
- as to which compliance with your duty is waived by the insurer.

### Non-disclosure

If you fail to comply with your duty of disclosure, the insurer may be entitled to reduce its liability under the contract in respect of a claim, refuse to pay the claim or may cancel the contract. If your non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning.

### Claims Made and Notified Basis of Coverage

The Medical Malpractice Insurance Policy is issued on a 'Claims made and Notified' basis.

This means that the Insuring Clause responds to:

- a) claims first made against you during the policy period and notified to the insurer during the policy period, provided that you were not aware at any time prior to the policy inception of circumstances which would have put a reasonable person in your position on notice that a claim may be made against him/her; and
- b) written notification of facts pursuant to section 40(3) of the Insurance Contracts Act 1984. The facts that you may decide to notify, are those which might give rise to a claim against you. Such notification must be given as soon as reasonably practicable after you become aware of the facts and prior to the expiry of the policy period. If you give written notification of facts the policy will respond even though a claim arising from those facts is made against you after the policy has expired. For your information, section 40(3) of the Insurance Contracts Act 1984 is set out below:

"S40(3) Where the insured gave notice in writing to the insurer of facts that might give rise to a claim against the insured as soon as was reasonably practicable after the insured became aware of those facts but before the insurance cover provided by the contract expired, the insurer is not relieved of liability under the contract in respect of the claim when made by reason only that it was made after the expiration of the period of insurance cover provided by the contract."

When the policy period expires, no new notification of facts can be made on the expired policy even though the event giving rise to the claim against you may have occurred during the policy period.

### Retroactive Date

You will not be entitled to indemnity under your new policy in respect of any claim resulting from an act, error or omission occurring or committed by you prior to the retroactive date, where one is specified in the policy terms offered to you.

### Subrogation Waiver

Our policy contains a provision that has the effect of excluding or limiting our liability in respect of a liability incurred solely by reason of the Insured entering into a deed or agreement excluding, limiting or delaying the legal rights of recovery against another.

### Privacy Statement

The Privacy Act 1988 (Cth) (as amended) requires us to inform you that:

#### Purpose of collection

We collect personal information (this is information or an opinion about an individual whose identity is apparent or can reasonably be ascertained and which relates to a natural living person) from or about you, for the purposes of:

- identifying you when you do business with us;
- establishing your requirements and providing you with the appropriate product or service including evaluating your application for insurance and any request for amendment to any insurance provided;
- setting up, issuing, administering and managing the insurance provided following acceptance of an application;
- assessing and investigating and, if covered, managing claims made in relation to any insurance you have with us or other companies within the Suncorp group; and
- understanding your needs and improving our financial products and services, including training and developing our staff and representatives.

We may use and disclose your personal information for a secondary purpose related to those purposes listed above, where you would reasonably expect us to sue or disclose your personal information for that secondary purpose. In the case of sensitive information, any secondary purpose, use or disclosure will be directly related to the purposes listed above.

#### Disclosure

When necessary and in connection with the purposes listed above, we may disclose your personal information to, and/or receive some personal information from:

- other companies within the Suncorp group;
- intermediaries including your agent, adviser, a broker, a representative acting on your behalf, other Australian Financial Services Licensees or our authorised representatives and our agents;
- government bodies, law enforcement or statutory bodies, other insurance companies, reinsurers, financial institutions, insurance and claims reference providers, credit agencies, loss assessors, financiers or investigative service providers;
- mailing houses, customer research organisations;
- legal and other professional advisers; and
- other service providers, hospitals, medical and health professionals.

## Marketing purposes

We would like to use and disclose your personal information to keep you up to date with the range of products and services available from Suncorp. Generally, our companies in the Suncorp group will use and disclose your personal information for Suncorp's marketing purposes. We may also use your personal information for the purpose of marketing other products and services of third parties we think may be of interest to you. If you do not want us to use and disclose your personal information for the purpose of marketing products and services to you, you should contact us and tell us. Please contact us on the details provided on the last page of this Proposal Form.

## Disclosure of personal information overseas

Our business is trans-Tasman and therefore we will have instances where for the purposes detailed above we may send your personal information to other companies in Suncorp who are in either in Australia or New Zealand. There are also other instances where we may have to send your personal information overseas or collect personal information from overseas. These instances include:

- when you have asked us to do so;
- when we are authorised or required by law to do so;
- when we have outsourced a business activity or function to an overseas service provider with whom we have a contractual arrangement;
- certain electronic transactions; or
- it is necessary in order to facilitate a transaction on your behalf.

## Consequences if information is not provided

If you do not provide us with the information we need we will be unable to administer your policy or manage any claim under your policy.

## Access

You can request access to the personal information we hold about you by contacting a Vero office at one of the addresses shown on the last page of this Proposal Form. In some circumstances we are able to deny your request to your personal information, such as when it is unlawful to give it to you. If we deny your request for access, we will tell you why.

## Privacy Statement Issued

Vero Insurance Limited – registered office Level 18, 36 Wickham Terrace, Brisbane, Queensland 4000.

## General Insurance Code of Practice

Vero Insurance Limited (Vero) has adopted the General Insurance Code of Practice which has been developed by the Insurance Council of Australia. The Code is designed to promote good relations and good insurance practice between insurers, intermediaries and consumers.

The Code sets out what insurers must do when dealing with policyholders/the insured. Please contact Vero for more information about the Code, if required.

## Our Complaints Handling Procedures

### Resolving your complaints

If you think we have let you down in any way, or our service is not what you expect (even if through one of our agents or representatives), please tell us so we can help. You can tell us by phone, in writing or in person.

Should you tell us in writing it will help to send us the full details of your complaint together with any supporting documents and an explanation of what you want us to do. If you would like to come in to talk to us face to face, please call and we will arrange an appointment for a meeting.

### What we will do to resolve your complaint

When you first let us know about your complaint or concern the person trying to resolve your complaint will listen to you, consider the facts and contact you to resolve your complaint as soon as possible, usually within 24 hours.

If you are not satisfied with this person's decision on your complaint, then it will be referred to the relevant Operational Manager, who will contact you within 5 working days.

Should you not be satisfied with the Operational Manager's decision, then it will be referred to the General Manager (or their delegate). We will send you our final decision within 15 working days from the date you first made your complaint.

### What if you are not satisfied with our final decision?

We expect our procedures will deal fairly and promptly with your complaint. However if you are not satisfied with our final decision there are external dispute remedies such as mediation, arbitration or legal action.

**Guidelines to help you complete this Proposal Form**

1. Failure to disclose all material information that is likely to influence the acceptance of the risk or the terms applied could invalidate the insurance. If you are in any doubt as to whether any information is material, it should be disclosed.
2. Where the space provided is insufficient for your replies, please provide these separately and attach to this Proposal Form.
3. Reference to Insured in this Proposal Form means:
  - the entity or entities named in question 1; and
  - the past and/or present employees, sole practitioners, partners or directors of the entity or entities named in question 1.
4. Reference to "North America" in this Proposal Form means the United States of America and Canada and their respective territories and protectorates.

**Section 1 – details of the insured**

1. Name of all entities to be insured

ABN:

ABN:

2. Telephone Number ( ) Facsimile Number ( )

Email Address

Website Address

3. Address of Principal Office  State  Postcode

4. Address(es) of other Office(s)

State  Postcode

State  Postcode

5. Date business established  /  /

6. a) Type of medical establishment

b) Please advise what percentage of the Insured's activities is represented by each of the following types of health care services.

Audiology	<input type="text"/> %	Optometry	<input type="text"/> %
Clinical Trials*	<input type="text"/> %	Organ Transplant	<input type="text"/> %
Cosmetic Surgery - elective	<input type="text"/> %	Other Surgical	<input type="text"/> %
Cosmetic Surgery - non elective	<input type="text"/> %	Paediatrics	<input type="text"/> %
Dental	<input type="text"/> %	Pathology	<input type="text"/> %
Drug/Alcohol Dependency	<input type="text"/> %	Physiotherapy	<input type="text"/> %
Eye Surgery	<input type="text"/> %	Podiatry	<input type="text"/> %
Gender Reassignment	<input type="text"/> %	Radiography/Medical Imaging/Sonography	<input type="text"/> %
General Medical	<input type="text"/> %	Psychiatric	<input type="text"/> %
Geriatric	<input type="text"/> %	Termination of Pregnancy	<input type="text"/> %
Gynaecological	<input type="text"/> %	Other (please specify)	<input type="text"/>
IVF/Assisted Conception	<input type="text"/> %		<input type="text"/> %
Obstetrics/Maternity	<input type="text"/> %		<input type="text"/>
<b>Total</b>			<b>100%</b>

\* If cover is required for clinical trials please complete the clinical trial supplementary proposal form available from [www.veroprofin.com.au](http://www.veroprofin.com.au)

**Section 1 – details of the insured: 6 continued**

c) Are there any intended changes to the professional services described in Q6 b. Yes  No

If Yes, please provide details

7. Has the Insured conducted any other health care service or activity other than described in 6b above in the past? Yes  No

If Yes please advise:

a) The type of health care service or activity conducted.

b) The reason the Insured ceased to conduct the health care service or activity.

c) Over what period the health care service or activity was conducted.

From  To

d) The annual gross fees/turnover derived from the health care service or activity  \$

8. If patients stay overnight at the Insured's establishment, please state the total number and average daily occupancy for the following:

	Number	Average Daily Occupancy
a) beds	<input type="text"/>	<input type="text"/>
b) bassinets/cribs/cots	<input type="text"/>	<input type="text"/>
9. State number of patients annually:	<input type="text"/>	

10. Name of all principals, directors, partners	Age	Qualifications	Date Qualified	How long practising
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

11. Please state number of staff in each of the following professions/activities	Employees	Self employed	Employees	Self employed
<input type="text"/> Audiologists	<input type="text"/>	<input type="text"/>	<input type="text"/> Perfusionists	<input type="text"/>
<input type="text"/> Clerical Assistants	<input type="text"/>	<input type="text"/>	<input type="text"/> Pharmacists	<input type="text"/>
<input type="text"/> Dentists	<input type="text"/>	<input type="text"/>	<input type="text"/> Physiotherapists	<input type="text"/>
<input type="text"/> Enrolled Nurses (excluding midwives)	<input type="text"/>	<input type="text"/>	<input type="text"/> Registered medical practitioners	<input type="text"/>
<input type="text"/> Laboratory Technicians	<input type="text"/>	<input type="text"/>	<input type="text"/> Podiatrists	<input type="text"/>
<input type="text"/> Midwives	<input type="text"/>	<input type="text"/>	<input type="text"/> Radiographers, Sonographers, X-Ray Technicians	<input type="text"/>
<input type="text"/> Nursing Assistants/Personal Care Assistants	<input type="text"/>	<input type="text"/>	<input type="text"/> Registered Nurses (excluding midwives)	<input type="text"/>
<input type="text"/> Optometrists	<input type="text"/>	<input type="text"/>	<input type="text"/> Other (please specify)	<input type="text"/>
				<b>Total</b>
				<input type="text"/>
				<input type="text"/>

12. The Medical Malpractice Policy excludes cover to medical practitioners and dentists for their medical malpractice liability. Cover for employed medical practitioners and dentists may be available upon request. Tick here if this cover is required.

13. Are volunteers or students undertaking work experience at the Insured's establishment to be included under the Medical Malpractice insurance policy? Yes  No

If Yes, please advise:

a)	Number per year	Details of the health care services provided
Volunteers	<input type="text"/>	<input type="text"/>
Students	<input type="text"/>	<input type="text"/>

b) are volunteers or students either suitably qualified to provide the health care services or under the direct supervision of a suitably qualified medical practitioner at all times when providing the health care services? Yes  No

14. Is the Insured required to be licenced or accredited in order to practice the professional services for which cover is being requested? Yes  No

If Yes, has the licence or accreditation been in force at all relevant times? Yes  No

If No, please provide details

15. Is the Insured a member of any association or professional body or registered with any self - regulating organisation? Yes  No   
If Yes,

a) name of association, professional body or self-regulating organisation.

b) Has the Insured's membership or registration with such organisation ever been declined, withdrawn, suspended, declined or had conditions imposed? Yes  No

If Yes, please give full details

16. Is the Insured represented in any way outside Australia? Yes  No   
If Yes, please state Country, Fees / Turnover, Number of Staff and Number of Offices

Country	Fees/Turnover	Number of Staff	Number of Offices
<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="text"/>

17. Is the Insured represented in any way in North America? Yes  No

If Yes, please provide details

18. Please state gross fees / turnover (as applicable), payable by clients.

Location	Previous 12 months	Last 12 months	Next 12 months
a) Australia	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
b) elsewhere (excluding North America)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
c) in North America (including work performed outside those areas for persons, companies, firms, or organisations having an address therein)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
<b>Total of a), b) and c) above</b>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>

19. Stamp Duty Declaration – Please provide a percentage breakdown of fees / turnover by location as follows

NSW	%	VIC	%	QLD	%	SA	%	WA	%
TAS	%	ACT	%	NT	%	Overseas	%	<b>Total</b>	<b>100%</b>

20. Please provide details of the procedures in place for dealing with patient complaints.

21. Please advise how patient medical records are kept and for how long they are retained.

22. Does the Insured have procedures in place that comply with all applicable current regulations in respect of the sterilisation of instruments and the safe collection, storage and disposal of all waste including but not limited to sharps, dressings, blood products and other hazardous waste?

Yes  No

23. Does the Insured have any Medical Malpractice or Professional Indemnity Insurance currently in force?

Yes  No

If Yes, please state:

Name of Insurer

Renewal Date

/ /

Limit of Indemnity

Retroactive Date

/ /

Excess

**Section 2 – general details**

1. Has any insurer, in respect of the risks to which this proposal relates, ever:

a) declined a proposal, refused renewal or terminated an insurance?

Yes  No

b) required an increased premium or imposed special conditions?

Yes  No

c) declined an insurance claim by the Insured or reduced its liability to pay an insurance claim in full (other than by application of an Excess)?

Yes  No

If Yes to any of the above, please give details

**Section 3 – claims and circumstances**

1. a) Has any claim been made against the Insured or any principal, partner or director (either as a principal, partner or director of the Insured or of any previous business), consultant or employee in respect of the risks to which this proposal relates?

Yes  No

b) Has the Insured or any principal, partner, director, consultant or employee incurred any other loss or expense which might be within the terms of the Medical Malpractice cover?

Yes  No

If Yes in either case, please give details

Date of Claim or loss	Brief details of each Claim or loss	Cost (if any) of Claim paid or loss insured	Estimated outstanding loss
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$

2. What action has been taken to prevent a recurrence of the situation which gave rise to each claim or loss?

Four empty text input boxes for providing details on actions taken to prevent recurrence.

3. Is any principal, director, partner, consultant or employee, **after enquiry**, aware of any circumstances which might:

- a) give rise to a claim against the Insured or his/her predecessors in business or any of the present or former partners, principals, directors, consultants or employees? Yes [ ] No [ ]
b) result in the Insured or his/her predecessors in business or any of the present or former partners, directors, consultants, employees or principals incurring any losses or expenses which might be within the terms of the Medical Malpractice cover? Yes [ ] No [ ]
c) otherwise affect the Insurer's consideration of this Insurance? Yes [ ] No [ ]

If Yes to any, please give details, including maximum potential cost (by separate note if preferred)

Three empty text input boxes for providing details if 'Yes' to any of the questions above.

It is agreed that if such facts, circumstances or situations exist, whether or not disclosed, any claim arising from them is excluded from this proposed insurance policy.

Section 4 – Insurance

1. Please state Limit of Indemnity required under this Medical Malpractice insurance:

Radio button options for \$1,000,000, \$2,000,000, \$5,000,000, \$10,000,000, \$20,000,000, and Other, followed by a text input box for the dollar amount.

Declaration

I/We the undersigned duly authorised person(s) declare that:

- i. I am/we are authorised by each of the Insured to sign this Proposal Form; and
ii. the above statements are correct, true and complete; and
iii. no information material to this Proposal Form has been withheld; and
iv. I/we have read the important facts which you have put before me/us and I/we understand the advice given in relation to the duty of disclosure; and
v. I/we have diligently made all necessary and detailed enquiries in order to comply with the duty of disclosure; and
vi. I/we understand that no insurance is in force until such time as the insurer has confirmed acceptance of the proposed insurance; and
vii. I/we undertake to inform the insurer of any material alteration to these facts occurring before completion of the contract of insurance; and
viii. I/we acknowledge that the insurer relies on the information and representations in this Proposal Form and otherwise made by me/us in relation to this insurance; and
ix. except where indicated to the contrary, I/we understand that any statement made in this Proposal Form will be treated by the insurer as a statement made by all persons to be insured; and
x. I/we have read Vero's Privacy Statement on this Proposal Form, and consent to the use, disclosure and obtaining of personal information about the Insured for the purposes shown in the Privacy Statement.

Signed [ ]
Name of Partner(s) or Director(s) [ ]
On Behalf of (Insert Name of Firm) [ ]
Date [ ]

We recommend that you keep a record, including copies of letters and this Proposal Form, of all information supplied to us for the purpose of entering into this contract.

## How to contact Vero Profin

### New South Wales

Locked Bag 25,  
Australia Square, Sydney NSW 1215  
DX 10282 Sydney Stock Exchange  
Tel (02) 8273 4292  
Fax (02) 8273 4323

### South Australia

GPO Box 1619  
Adelaide SA 5001  
DX 552 Adelaide  
Tel (08) 8205 5208  
Fax (08) 8205 5199

### Queensland

GPO Box 41  
Brisbane QLD 4001  
DX 200 Brisbane  
Tel (07) 3246 6169  
Fax (07) 3246 6024

### Western Australia

GPO B78  
Perth WA 6838  
DX 125 Perth  
Tel (08) 9211 4177  
Fax (08) 9211 4189

### Victoria

PO Box 294  
Collins St West, Melbourne VIC 8007  
DX 273 Melbourne  
Tel (03) 9245 8218  
Fax (03) 9245 8112