Avant Practitioner Indemnity Insurance Policy

Application form

Practitioner Indemnity Policy with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765
Effective: March 2020

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.

It is important that the information you provide is complete and accurate. Where there is not sufficient space please provide your answers within the 'additional information' section or on a separate page. If you fail to disclose material information we may be entitled to reduce our liability or void the contract entirely.

Avant takes data privacy very seriously. By providing your personal information to Avant you consent to your personal information being collected, held, used and disclosed by Avant in accordance with the Avant Privacy Policy found at **avant.org.au/Privacy-Policy**.

If you have any queries or need to access policy documents, you can access them online at **avant.org.au** or contact us on **1800 128 268**.

1. Your details

Title		First name		Last name	
Gender	☐ Male ☐ Female	Date of birth		Mobile	
Email				Work telephone	
Alternate email					
Residential address					
Primary practice address					
Preferred mailing address	☐ Residential ☐ Practice				

Electronic communications disclosure and consent

Note: You may alter these consents at any time.

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**

Would you like to receive electronic communications from Avant, such as specialist medico-legal newsletters and alerts, product updates and offers relevant to you? ☐ Yes ☐ No

How would you like to receive your notice of Annual General Meeting? ☐ Email ☐ Post

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? ☐ Yes ☐ No — If **YES** please **attach a copy** ☐ 422 ☐ 457

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

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

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 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 billings for public practice below.

c) 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 **(only complete if YES above)**	$

d) 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.

e) 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 our PSS 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? ☐ Yes ☐ No

For more information about this option and what this covers you for, please refer to Part C of the Avant Practitioner Indemnity Insurance Policy

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

g) 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

h) 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

i) 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

j) 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	

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Would you like information on any the following?

☐ Life insurance	☐ Travel insurance	☐ Business insurance	☐ Practice insurance	☐ Health insurance

Office use only	
Campaign code	

*IMPORTANT: Professional indemnity insurance products available from Avant Mutual Group Limited ABN 58 123 154 898 are issued by Avant Insurance Limited, ABN 82 003 707 471, AFSL 238 765. The information provided here is general advice only. You should consider the appropriateness of the advice having regard to your own objectives, financial situation and needs before deciding to purchase or continuing to hold a policy with us. For full details including the terms, conditions and exclusions that apply, please read and consider the policy wording and Product Disclosure Statement, which is available at avant.org.au or by contacting us on 1800 128 268. MJN219.15 04/20 (1163-8)

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8. Additional information

Section number	Additional details

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