Avant Practice Medical Indemnity Policy
GP practice application form

Practice Medical Indemnity Policy with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765
Effective: February 2022

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.

1. Practice details

Full name of principal business to be insured (incl. trading name)			
ABN/ACN		Phone number	
Practice website		Email address	
Practice address			
Owner of the practice			
Is a doctor or medical professional an owner or director of the practice?	☐ Yes ☐ No		
Authorised contact name			
Authorised contact phone		Authorised contact email	

2. Healthcare services

Your policy covers you for the healthcare services that you disclose to Avant. 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.

What healthcare services are provided at the practice?	☐ General practice family Medicine	☐ General practice skin cancer medicine
	☐ General practice including allied health	☐ General practice, skin cancer and allied health
What was your healthcare services gross billings for the last financial year?		
Do you expect your healthcare services gross billings this financial year to be similar?	☐ Yes	☐ No
If **NO**, what is your expected healthcare services gross billings for this year?		
Do you do any cosmetic procedures in the practice?	☐ Yes	☐ No
If **YES**, what % of the healthcare services gross billings is for cosmetic procedures		
Is the practice appointment only or do you accept walk-ins?	☐ Appointment only	☐ Walk-ins accepted

3. Persons engaged in the business

Does the practice employ a full-time practice manager with more than 2 years' experience in management? ☐ Yes ☐ No

Are there regular staff meetings and training sessions held for all practice staff? ☐ Yes ☐ No

Does the practice check at commencement and annually that each medical practitioner or contractor providing healthcare services holds medical indemnity insurance and is registered and appropriately qualified to provide the services that they provide? ☐ Yes ☐ No

Please provide details of people involved in the business. For medical practitioners, please provide details on a separate page.

You may be entitled to discounts on your practice premium if there are doctors in your practice who are insured with Avant.

Staff type	Total number	How many are insured with Avant?	Employment arrangement e.g. contractor, employed etc.	How many rent rooms?
Registrar				
Medical practitioner				
Allied health practitioner				
Nurse		N/A		
Midwife		N/A		
Other staff e.g. technician, administration staff etc.		N/A		

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

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

Do any employees or contractors have conditions, limitations or undertakings on their registration? If **YES**, please provide details on a separate page. ☐ Yes ☐ No

4. Claims and insurance history

Have any medical indemnity claims been made against the practice in the last 10 years? If **YES**, please provide details on a separate page. ☐ Yes ☐ No

Has the practice held professional indemnity insurance in the past? If **YES**, with who and when? ☐ Yes ☐ No

Insurer	Retroactive date (This is typically the date when your practice started)	Policy start date	Policy end date

5. Insurance requirements

What date would you like the policy to start?

If we approve your application and you then accept our offer of insurance, the cover will start from the date we approve your application unless you request a later date.

Do you require retroactive cover? (This is to ensure we cover you from the time that your practice started operating) ☐ Yes ☐ No

If **YES**, please nominate a retroactive date

Please select a limit of indemnity ☐ $5 million ☐ $10 million ☐ $20 million

5. Insurance requirements (cont'd)

Does the practice require the following optional extensions? (An additional premium will apply)	
Reinstatement	☐ Yes ☐ No
Defence costs in addition to the limit of indemnity	☐ Yes ☐ No
Public liability (We will provide you an additional form to complete if you would like to include this cover)	☐ Yes ☐ No

6. 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 ☐ Network only ☐ Email and Network ☐ 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 *Note: You may alter these consents at any time.*

You will receive the policy wording, 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

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 Ddeclaration

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. 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
ii. I am carrying on a business with a turnover of less than $2 million in the last financial year.	☐ Yes ☐ No
iii. 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 number	Additional details