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UNDERWRITING

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# MEDICAL MALPRACTICE ADDENDUM

1.Please provide gross Fees/Turnover, including gross fees paid to sub-contractors.

| Location | Previous 12 months | Last 12 months | Next 12 months |
|---|---|---|---|
| Australia | $ | $ | $ |
| Other (exc USA/Canada) | $ | $ | $ |
| USA/Canada | $ | $ | $ |
| **Total** | $ | $ | $ |

2. Number of full-time equivalent staff by category:

| | | | |
|---|---|---|---|
| Surgeons | | Midwives | |
| Doctors | | Nurse Anaesthetists | |
| Anaesthetists | | Attendant Carers | |
| Dentists | | Dental Technicians | |
| Interns | | Undergraduate or student staff | |
| Medical Imaging technicians | | Other Medical, Health or allied employees (please specify below) | |
| Laboratory technicians | | Clerical / Administrative | |
| Pharmacists | | Other Sta (please specify below) | |
| Registered Nurses | | **Total** | |

3. Please provide patient percentages in the following categories:

| Patient Category | % | Patient Category | % |
|---|---|---|---|
| Audiology | | Optometry | |
| Acupuncture | | Oral and Maxillofacial Surgical | |
| Allied Health Therapy (please specify below) | | Paediatrics | |
| Casualty / Emergency | | Palliative | |
| Chiropractic | | Pathology | |
| Day Surgery | | Physiotherapy | |

| | | | |
|---|---|---|---|
| Drug / Alcohol Dependency or Rehabilitation | | Psychiatric | |
| Elective Cosmetic | | Radiology / Medical Imaging | |
| General Dental and Orthodontics | | Senile or Aged | |
| General / Medical | | Speech Pathology | |
| Gynaecological | | Podiatry Surgical (Minor) | |
| IVF / Fertility | | Surgical (Major) | |
| Obstetrics / Maternity | | Other (please specify below) | |
| | | **Total** | 100% |

**Allied Health and Other Additional Information**

| |
|---|
| |

**4. Please advise the Number of Beds per the following categories**

| Category Number of Beds | Number | Category Number of Beds | Number |
|---|---|---|---|
| Intensive Care | | Other Hospital Beds | |
| Emergency / Casualty | | Nursing Home Beds | |
| Day Surgery | | Self-Care Units | |
| Maternity | | Other (please specify below) | |
| Children's Ward | | **Total** | |

**5. Does the Insured subcontract out any of their Professional Services/Activities?**

**(i) Medical Imaging equipment (Cat Scanner, MRI etc)**

**(ii) Pathology Laboratory**

If Yes to Pathology Laboratory, please advise the % of your total revenue %

**(iii) Does the Insured anticipate any changes to the above Activities in the next 12 months?**

No ☐ Yes ☐ If Yes, please provide details:

6. Does the Insured hold any licence or accreditation which is required in order to provide professional services or activities for which cover is requested?

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

Yes ☐ No ☐ If No, please provide details

# DECLARATION

Please Note: Signing the Declaration does not bind either the proposed Insured or the Insurer to execute this or any insurance whatsoever.

| | |
|---|---|
| Signed | |
| Name of Partner(s) or Director (s) | |
| On behalf of | |
| Date | / / |

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