



## PROFESSIONAL INDEMNITY INSURANCE APPLICATION

The insurance for which you are applying is underwritten by HOLLARD

### Member Details

PSSA No: (if available)

Surname:	Title:	Initials:	Full Names:	
ID No:	Date of Birth:		SAPC No: <b>COMPULSARY</b>	Maiden Name:
Home Tel:	Cell No:	E-Mail:		
Postal Address:				Code:
Street Address:				Code:

### Employer Details

Full Name Of Practice Or Employer:		Y Number of Pharmacy:
Postal Address of Employer:		Code:
Work Tel No:	Fax No:	E-Mail:

### Qualifications

Qualification:	Qualification Date:	Institution:

### Incidents or Claims and Previous Insurance (COMPULSORY) – please complete this section

Are you directly or indirectly involved in any way in respect of services and / or activities in relation to COVID-19?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you directly or indirectly involved in any way in rendering services and / or activities in relation to COVID-19 Clinical / Medical Trials?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you directly or indirectly involved in any way in rendering services and / or activities in relation to the administration of the COVID-19 Vaccination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If other activities – please detail services in respect of COVID-19.

### Details of any Errors / Omissions or Malpractice incidents, claims made or intimated against me:

• Any claims made against the applicant during the last 10 years	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• Any circumstances / complaints which may give rise to a claim being made against the applicant	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• Any application for insurance of this nature ever been declined, cancelled, or has renewal been refused or have special terms been imposed	Yes <input type="checkbox"/>	No <input type="checkbox"/>

(If yes, attach details to application form)

### Split of Professional Services (Please indicate with a X)

If services are across both Private and State-Owned facilities - split accordingly

Do you provide your services in **Private Facilities**?     YES     NO

If YES, What Percentage?     Less than 25%     More than 25%     More than 50%     100%

  

Do you provide your services in **State Owned Facilities**?     YES     NO

If YES, What Percentage?     Less than 25%     More than 25%     More than 50%     100%



### Payment by Bank Debit Order raised by the PSSA:

Bank Name:										
Branch Name:										
Branch Code:										
Account Number:										
Type of Account:	Annually	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	1st	<input type="checkbox"/>	15th	<input type="checkbox"/>		
Name of Account Holder:	<b>Or on the first business day thereafter</b>									

I, \_\_\_\_\_ hereby authorise the PSSA to debit my banking account with the applicable fees.

I confirm my membership of the Pharmaceutical Society of SA.

I declare and warrant that after enquiry all statements and particulars contained in this proposal and addenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way, I will advise the Underwriters as soon as possible. I understand that failure to disclose any material facts, which would be likely to influence the acceptance and assessment of the proposal, may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I hereby agree and accept that this declaration shall be the basis of the contract between both parties if entered into.

**SIGNATURE / AUTHORIZATION**

**DATE**

Hollard Insurance Company Limited are Authorised Financial Services Providers

<b>Title:</b>	<b>Initials:</b>	<b>Surname:</b>	<b>PSSA Number: (if available)</b>
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#### RATING TABLE FOR INDIVIDUALS (*Rates effective from 01/09/2023*)

#### MEDICAL MALPRACTICE & PROFESSIONAL INDEMNITY ONLY

**Please indicate with a ✓ which option you choose**

Category of Practice	Rates effective 01/09/2023 A – R5 million			Rates effective 01/09/2023 B – R7.5 million			Rates effective 01/09/2023 C – R10 million			Rates effective 01/09/2023 D – R15 million			Rates effective 01/09/2023 E – R20 million							
	Annual Premium Incl. VAT	✓ Monthly Premium Incl. VAT	✓	Annual Premium Incl. VAT	✓ Monthly Premium Incl. VAT	✓	Annual Premium Incl. VAT	✓ Monthly Premium Incl. VAT	✓	Annual Premium Incl. VAT	✓ Monthly Premium Incl. VAT	✓	Annual Premium Incl. VAT	✓ Monthly Premium Incl. VAT	✓					
Pharmacy nurses / Wound care nurses	R1,776		R148.50		R1,920		R160.00		R2,076		R173.00		R2,484		R207.00		R2,976		R248.00	
Pharmacy Technicians	R732		R61.00		R924		R77.00		R1,008		R84.00		R1,200		R100.00		R1,440		R120.00	
Pharmacist's Assistants	R540		R45.00		R660		R55.00		R720		R60.00		R840		R70.00		R1,020		R85.00	
Pharmacy Technician Trainees / Students	R210																			

1. Premiums include VAT at 15%.
2. Premiums include administration fee of 15%.
3. Excesses are R2,500.00 each and every claim.
4. Hollard/ITOO are to issue master policy.
5. Medical Malpractice for Medical Professions April 2021 wording.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**



**ADDITIONAL COVER INCLUDED:**

<b>Extension/s: (Sub Limit of Indemnity – included in Main Limit)</b>	<b>Sub Limit of Indemnity (Included in the main Limit)</b>	<b>Deductible (each &amp; every claim)</b>
Breach of Confidentiality	R 250 000.00	R 2 500.00
Business Identity Theft	R 500 000.00	Nil
Defamation	R 250 000.00	R 2 500.00
Documents	R 250 000.00	R 2 500.00
HPCSA / Other Statutory Body Costs	R 250 000.00	R 2 500.00
Statutory Defence Costs (Sub limited under and applicable to PL Section only)	R 100 000.00	R 1 000.00
Wrongful Arrest (Sub limited under and applicable to PL Section only)	R 100 000.00	R 1 000.00
36 months Run Off Cover (as amended) (Clause 9.6 of Policy wording)	Included	