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: COMPULSARY	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 ☐**	**No ☐**
Are you directly or indirectly involved in any way in rendering services and / or activities in relation to COVID-19 Clinical / Medical Trials?	**Yes ☐**	**No ☐**
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 ☐**	**No ☐**
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 • Any circumstances / complaints which may give rise to a claim being made against the applicant	**Yes ☐** **Yes ☐**	**No ☐** **No ☐**
• Any application for insurance of this nature ever been declined, cancelled or has renewal been refused or have special terms been imposed	**Yes ☐**	**No ☐**
(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%

1. **For Bank / Internet Transfers please use the following account:**
*(Please note that this bank detail is **not the same** for PSSA membership fees)*

Account name: **Pharmaceutical Society of SA - PIP**
Bank: **Standard Bank**
Branch: **Lynnwood Ridge**
Branch code: **051001**
Account number: **011206535**
Reference: **Membership number/Initials and surname**
Please email the proof of payment together with the application forms to sinah@pssa.org.za

2. **Payment by Bank Debit Order raised by the PSSA:**

Bank Name:									
Branch Name:									
Branch Code:									
Account Number:									
Type of Account:		Annually	☐	Monthly	☐	**1st**	☐	**15th**	☐
Name of Account Holder:				**Or on the first business day thereafter**					

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

Title:	**Initials:**	**Surname:**	**PSSA Number:** (if available)

RATING TABLE FOR INDIVIDUALS (*Rates effective from 01/07/2021*)
MEDICAL MALPRACTICE & PROFESSIONAL INDEMNITY ONLY

Please indicate with a ✓ which option you choose

Category of Practice	**Rates effective 01/07/2021 A – R5 million**				**Rates effective 01/07/2021 B – R7.5 million**				**Rates effective 01/07/2021 C – R10 million**				**Rates effective 01/07/2021 D – R15 million**				**Rates effective 01/07/2021 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 Technicians	R696		R58.00		R882		R73.50		R960		R80.00		R1,164		R97.00		R1,386		R115.50	
Pharmacist's Assistant	R528		R44.00		R624		R52.00		R684		R57.00		R816		R68.00		R990		R82.50	
Pharmacy Technician Trainees	R200																			

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:

Extension/s : **(Sub Limit of Indemnity – included in Main Limit)**	**Sub Limit of Indemnity** (Included in the main Limit)	**Deductible** (each & every claim)
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	