



## PPS PROFESSIONAL INDEMNITY INSURANCE APPLICATION

### COMPULSORY TO BE A PSSA MEMBER

The insurance for which you are applying is managed and underwritten by PPS Health Professions Indemnity  
Email application form to [indemnity@pssa.org.za](mailto:indemnity@pssa.org.za)

1. MEMBER PERSONAL DETAIL						
PSSA Nr <i>If available</i>	*SAPC Registration P-Number			Title	Initials	
Surname			Maiden surname			
Full names				Date of Birth		
ID Number	Nationality			Passport number		
Postal address						
Postal city		Province		Postal Code		
Cell Nr		Email Address				
2. EMPLOYMENT						
Full name of Practice / Employer				Y-Nr of Pharmacy		
Province	Business Tel Nr	Business Email				
Is your primary workplace more than 20 km away from your regular residential address?				Yes	No	
3. EDUCATION AND QUALIFICATIONS						
Qualification	Year Qualified	Institution				
4. INSURANCE HISTORY - Please indicate (✓)						
4.1 Have you had any professional liability insurance cover or indemnity protection before?						
Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>If Yes, please provide details of all previous insurance cover or indemnity protection memberships:</i>				
Insurer / member organisation		Date from:		Date to:		
4.2 Have you at any stage practiced medicine in private practice without professional indemnity protection?					Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.3 Have you been involved in any claim for compensation or damages, inquest or medico-legal action relating to your professional practice regardless of the outcome in the preceding year? (If yes, please attach relevant documentation)					Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.4 Have you ever been cautioned by a law enforcement agency or convicted of any criminal offence? (You do not need to consider details of minor traffic offences unless it involved alcohol or drugs)					Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.5 Is there anything else you consider relevant to share with us, relating to your previous professional liability history?					Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments:						



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5. INDEMNITY INSURANCE COVER							
Rating Table for Individuals (Rates effective 01/04/2026) Medical Malpractice & Professional Indemnity Only							
Please indicate (✓) Applicable Rating Class					Cover limits		
Clinical Practise Discipline		Premium Annual	✓	Premium Monthly	✓	Each incident	Annual aggregate
1	B. Pharm student	R100		N / A		R5 million	R10 million
2	Interns and Community Service	R500		R41.67		R7.5 million	R10 million
3	Non-dispensing pharmacist (eg: Academic, Medical Scheme Administrators, DUR Pharmacists and other consultants)	R750		R62.50		R5 million	R10 million
4	State employed Dispensing and Compounding Pharmacist	R1 900		R158.33		R20 million	R20 million
5	Private Dispensing, Wholesale/Distribution and Industrial/Manufacturing Pharmacist, Non-Practising Clinical Consultant	R2 500		R208.33		R20 million	R20 million
6	State employed Responsible Pharmacist	R1 900		R158.33		R20 million	R20 million
7	Private Responsible Pharmacist	R3 570		R297.50		R20 million	R20 million
8	S22A(15) permit holders (eg: PCDT), Private Compounding and Clinical Trial Pharmacist	R3 570		R297.50		R20 million	R20 million
<p>1. All amounts are inclusive of VAT at 15%.</p> <p>2. Premiums are annual amounts and can be paid either through a single payment or equal monthly payments.</p> <p>3. All premium payments to be through debit order with premium payment a condition of cover.</p> <p>4. *** Cover for Pharmacist Assistants and Technicians as well as Wound Care Nurses is only available through group pharmacy policies unless the individual in question qualifies for PPS Group membership.</p> <p>I further understand that, should I not already be a member of the Professional Provident Society (PPS), the acceptance of this option will automatically grant me membership of PPS. As a graduate professional meeting the eligibility requirements of the Society, I am entitled to share in the benefits of the PPS product range, which includes insurance, investments and healthcare products. Following the registration, PPS will provide me with my unique membership number.</p>							
6. DEBIT ORDER AUTHORIZATION							
<p>I, _____ (accountholder), hereby authorise PPS Health Professional Indemnity to debit my bank account with the applicable fees/premiums as per the payment term and date indicated below:</p>							
Bank Name	Type of account	Payment Frequency	Annually <input type="checkbox"/>	Monthly <input type="checkbox"/>			
Branch	Branch code	Collection date	1st <input type="checkbox"/>	15th <input type="checkbox"/>			
Account Number	Accountholder SIGN						

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.

By signing the application form, irrespective as to how such information is submitted, you consent to the collection, collation, processing, and storing of such information and the use and disclosure of such information in accordance with PSSA's Privacy Policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_