Rural General Practitioners
Medical Indemnity Proposal Form

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| Personal details |
| First name:       |
| Last name:       |
| Name of Practice:       |
| Address of Practice:       |
| Postal address for correspondence:       |
| Practice phone number:       |
| Practice fax number:       |
| Home phone number:       |
| Mobile number:       |
| Email address:       |
| Name of rural public hospital(s) where you have admitting rights:       |
| Location:       |

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| Medical qualifications |
| Year first registered to practice medicine in Australia:        |
| **Qualification(s)** | **University or other institution** | **Year awarded** | **Country** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Are you a prinipal doctor for this practice?If yes, you are eligible for Practice Staff Cover. Please complete details on the next page to apply for this cover. For more information about Practice Staff Cover, please contact VMIA. | [ ]  Yes [ ]  No |
| Do you conduct cross-border work in your current practice?(Cross-border work refers to limited services in border towns of New South Wales and South Australia) | [ ]  Yes [ ]  No |
| Do you require retroactive cover for potential claims arising from the medical services you provided prior to taking out this medical indemnity insurance with VMIA?Please refer to the Important Information on the next page and provide details where relevant if you are applying for this cover. (Unlimited retroactive cover is available at an additional 50% of the selected cover option annual premium - only payable the first year). | [ ]  Yes [ ]  No |
| Are you aware of any circumstances that may give rise to a claim?If yes, please provide details in the claims information section on the next page. | [ ]  Yes [ ]  No |
| Are you aware of any material facts or circumstances (such as a conviction or previous medical indemnity insurance declined or cancelled) that may be relevant to our decision to provide cover?If yes, please provide details in the claims information section on the next page. | [ ]  Yes [ ]  No |
| Are you a Professional Locum?(Professional Locum means you are providing the majority of services as a locum within the State of Victoria) | [ ]  Yes [ ]  No |
| Are there, or have there been, any conditions, limitations or undertakings imposed on your registration?If ‘yes’ please provide details:       | [ ]  Yes [ ]  No |

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| Cover options (please select cover required by ticking the appropriate box below) |
| Cover start date:       |
| **Your required level of cover** | **Your annual gross earnings from private practice\*** |
| **$75,000 or more** | **Between$75,000 - $40,000** | **Less than $40,000** |
|  | Premium amount | Premium amount | Premium amount |
| 1a – Includes obstetrics, anaesthetic, procedural work | [ ]  $8,883.99 | [ ]  $6,010.20 | [ ]  $2,771.75 |
| 1b – Excludes obstetrics and includes anaesthetic, procedural work | [ ]  $6209.22 | [ ]  $4,391.78 | [ ]  $2,666.05 |
| Registrar – Includes obstetrics, anaesthetic, procedural work in a supervised capacity | [ ]  $1,233.14 | [ ]  $986.51 | [ ]  $616.57 |
| \* Annual Premium payable by Cover Option based on Estimated Annual Gross Earnings from 1 July 2024 to 30 June 2025 (inclusive of GST and statutory charges). Please note that for cover commencing after 1 July 2024, a pro-rata premium is calculated and charged from the date of inception to 30 June 2025. |
| Please confirm your Estimated Annual Gross Earnings from Practice Services:       |

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| Practice company staff cover |
| I am eligible for practice company staff cover and I require this extension for: |
| Name of General Practitioner:       |
| Name of practice:       |
| Trading as:       |
| ABN:       |
| Number of principal doctors:       |
| Number of non-principal doctors:       |
| Number of administrative staff:       |
| Number of nursing staff:       |

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| Retroactive cover |
| Retroactive cover is cover for incidents or circumstances which were not known or have not been previously reported to another insurer prior to the start date of cover under this program.Important Information: If you have not taken out run-off cover from your previous medical indemnity insurer and are opting not to purchase retroactive cover from VMIA, you will have an exposure for the claims and/or incidents that relate to treatment provided by you before you were insured with VMIA. Contact VMIA for further information.Please provide details of any incidents you are aware of that have occurred in the past that may give rise to a claim made against this policy. |
| **Date of incident** | **Patient name** | **Brief details of incident** | **Insurer** | **Reported** |
|   /  /     |       |       |       | [ ]  Yes [ ]  No |
|   /  /     |       |       |       | [ ]  Yes [ ]  No |
|   /  /     |       |       |       | [ ]  Yes [ ]  No |
|   /  /     |       |       |       | [ ]  Yes [ ]  No |

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| Non-disclosure |
| If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the contract in respect of a claim or may cancel the contract. If your non-disclosure is fraudulent, we may also have the option of voiding the contract from its beginning. Please note that your duty of disclosure applies also when you seek to amend, alter, vary, or endorse a policy. |

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| Privacy declaration |
| I declare that to the best of my knowledge and belief, the information in this form is true and correct and I have not withheld any relevant information.I consent to VMIA using personal information I have provided on this form for the purpose of assessing my insurance requirements and in assessing any future claims that may arise in relation to this insurance. However, I understand that if I choose not to provide the required details, this is my choice and that VMIA may not be able to assess my insurance requirements.I consent to VMIA disclosing personal information to other insurers, or as required by law. I consent to VMIA also disclosing personal information to and/or collecting additional information from investigators, legal advisers, medical advisers, actuaries or other advisers whom VMIA may engage to assist in processing this proposal for insurance and any subsequent claims. Where I have provided information about another individual (e.g. an employee or client), I declare that the individual has been made aware of the reason for the disclosure of their personal details to VMIA and of the contents of VMIA's Privacy Policy. I have read this declaration and understand my duty of disclosure and privacy obligations. |

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| Retroactive cover |
| The following provides details of any incidents I am aware of that have occurred in the past that may give rise to a claim made against this policy or any other material facts, or circumstances which may be relevant to VMIA’s decision to insure me. |
|       |
| By signing this form, I am confirming that all information provided is correct and that I have not withheld any relevant information. I have also read the Duty of Disclosure and Privacy Declaration and have complied with all requirements therein. |
| Signature: | Date:   /  /     |

On receipt, review and acceptance of this proposal, VMIA will provide you with a tax invoice, a Schedule of Insurance
and a Policy Wording. Payment must be made within 30 days of the date printed on the invoice for this cover to be valid. Please retain a copy of the proposal for your records and send the original signed proposal to VMIA. For all enquiries, contact VMIA:

**Victorian Managed Insurance Authority**

ABN: 39 682 497 841

Level 10 South, 161 Collins Street, Melbourne 3000

PO Box 18409 Collins St East, Victoria 8003

**P:** (03) 9270 6900 **E:** contact@vmia.vic.gov.au

Any personal information you provide directly (or provided by a health service under s141 of the Health Services Act 1988) in this Form is being collected
by the VMIA for the purpose of administering VMIA’s functions, under s6 of the Victorian Managed Insurance Authority Act 1996 (Vic), namely to provide insurance, risk advisory and claims handling services. Any personal information you provide will be treated according to the requirements of the Privacy
and Data Protection Act 2014 (Vic), the Information Privacy Principles, the Victorian Protective Data Security Standards, the Health Records Act 2001 (Vic) and the Health Privacy Principles. VMIA will not act or engage in any practice that contravenes these provisions. Information will be handled in line with VMIA's Privacy Policy. You have the right to access and correct your personal information. Requests for access should be sent to the Privacy Officer, VMIA, PO Box 18409, Collins Street East, VIC 8003 or privacy@vmia.vic.gov.au.