



## General Practitioner Insurance Information

Please complete and return this form to Doctors' Choice as soon as possible by email at [service@drschoice.com.au](mailto:service@drschoice.com.au) or fax on (08) 6323 4668 or post to Suite 19, 23 Mill Point Road, South Perth WA 6151. It is important that you take care and provide accurate and complete information so we can properly determine the policy that is right for you. If you have any questions when completing this form, please contact us on 1800 DRS CHOICE (1800 377 246).

### Your Details

Title	First name	Middle name(s)	Last name <i>(also indicate former/maiden name if applicable)</i>
Preferred name <i>(if applicable)</i>	Gender	Date of birth (dd/mm/yy)	
	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X	____/____/____	

### Your Contact Information

Preferred contact method	<input type="checkbox"/> Email <input type="checkbox"/> Mobile <input type="checkbox"/> Other phone	
Email <i>(feel free to include more than one and, if so, mark the preferred email address with an asterisk)</i>		
Mobile		
Other phone <i>(if applicable)</i>		
Residential address	Primary practice address	Other address <i>(if applicable)</i>
Electronic correspondence	We will provide all correspondence to you electronically. However, if you would prefer to receive correspondence by post, please tick this box. <input type="checkbox"/>	
Hard copy correspondence	There may be times when we are legally required to mail a hard copy document to you so <b>please indicate your preferred postal address:</b> <input type="checkbox"/> Residential <input type="checkbox"/> Primary practice <input type="checkbox"/> Other	

## Your Qualifications

To save you time, we will obtain some of the information we need about your qualifications and college memberships from the public Australian Health Practitioner Regulation Agency (AHPRA) Register of Practitioners.

If you are currently in a College training program, what date did you commence that program?	_____(dd)/_____(mm)/_____(yy)
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## Your Registration

To save you time, we will obtain your current registration details from the public AHPRA Register of Practitioners.

In relation to your registration in any country:

Have you ever been refused registration, deregistered or suspended from practice as a medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there or have there been any conditions, undertakings, reprimands or notations placed on your registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Your Current Practice Information

Geographical areas in which you currently practice <i>(please indicate all)</i> :	
<input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> NSW <input type="checkbox"/> VIC <input type="checkbox"/> QLD <input type="checkbox"/> NT <input type="checkbox"/> ACT <input type="checkbox"/> Overseas	
Do you practice in an area classified as Rural Remote Metropolitan Area (RRMA) 3-7 or R1, R2, R3, Rem 1 and Rem 2) by the Department of Health and Ageing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Gross annual billings<sup>#</sup></b>	
What is the estimate of your current gross <u>annual</u> billings <sup>#</sup> from work for which you require indemnity?	\$
<p><i><sup>#</sup>Gross annual billings means the total of all billings generated by you from <u>all areas of practice</u> for which you require indemnity for a financial year (in your name or for which you are personally liable), whether the funds are retained by you or not, and before any apportionment or deduction of expenses and/or tax <u>including</u>:</i></p> <ul style="list-style-type: none"> <li>• Medicare benefits</li> <li>• payments by individuals, the Commonwealth Department of Veterans' Affairs, workers' compensation schemes and third-party and/or vehicle insurers.</li> </ul> <p><i>Gross annual billings also <u>include</u> income you receive from other healthcare services provided by you such as professional fees for writing articles and incentive payments other than those made under the Australian Government's Practice Incentive Program (PIP). Gross annual billings do <u>not</u> include billings or income from healthcare services that you provide in the public system for which you have access to indemnity from the public hospital's indemnity scheme or your employer.</i></p>	

<b>Procedures</b>	
Skin cancer medicine - Do you specialise in skin cancer medicine and/or work in a skin cancer clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetrics - Do you require cover for induction or management of labour or for delivery of infants? <i>(Please disregard emergency assistance situations when answering this question.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Terminations of pregnancy - Do you require cover for:	
a) medical terminations of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) surgical terminations of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaesthesia - Do you require cover for regional, epidural or general anaesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Cosmetic procedures - Do you perform any cosmetic procedures#?</b> <i>(# Cosmetic procedures mean operations, procedures and treatments that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient's appearance or self-esteem as there are no underlying medical, clinical or pathological reasons for undertaking such procedures).</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you perform procedures or provide services which might be considered outside the normal scope of non-procedural general practice?</b> <i>If yes, please provide details in the notes section on page 6 (or separately).</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Supervising Registrars</b>	
<b>Do you currently supervise GP registrars?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Volunteering</b>	
<b>Do you/will you perform unpaid volunteer work* at professional sporting events?</b> <i>* Unpaid volunteer work means work without the expectation of payment apart from reimbursement or receipt of reasonable expenses e.g. travel, meals or accommodation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Overseas practice</b>	
<b>Do you intend to work overseas (paid or voluntary) in the next 2 years?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Clinical trials</b>	
<b>Are you participating, or have you participated, in a clinical trial or research project...</b>	
<b>where you are working directly for, or on behalf of, a pharmaceutical company?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>as a sponsor, initiator or administrator?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Medical Practices</b>	
<b>Are you an owner or part owner of a medical practice?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, would you like Doctors' Choice to provide you with advice regarding medical indemnity cover for your practice?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Overseas qualified doctors</b>	
For overseas doctors, please tick <u>all</u> that apply to you:	
<b>Working in Australia for less than 12 months</b>	<input type="checkbox"/>
<b>Working in Australia on a Visa</b>	<input type="checkbox"/> Visa 422 or <input type="checkbox"/> TSS Visa (457)
<b>Australian Medical Council (AMC) Pathway</b>	<input type="checkbox"/> Completed or <input type="checkbox"/> Completing

## Your Past Practice Information

Because medical indemnity claims or investigations can first be notified to you years after you have provided the relevant healthcare service, it is vital that at all times you are covered for your past practice through sufficient retroactive cover. Further, since 1 January 2016, medical practitioners are required to have appropriate retroactive cover in accordance with a revised registration standard of the Medical Board of Australia. The retroactive date of your insurance policy is the date from which your past work will be covered (unless you know or should have known that a claim might result from an incident or an incident is otherwise covered e.g. you have already notified the incident to your insurer or you are indemnified for the incident by a hospital or other employer). **If you move insurers, Doctors' Choice helps you make the switch so you have continuous cover in place. Your current insurance policy will indicate your retroactive date which we will obtain from your current insurer. However, if you have any questions or concerns about your retroactive date and/or any uncovered prior practice, please contact us on: 1800 DRS CHOICE / 1800 377 246.**

<b>Since your retroactive date, have you been involved in any cosmetic procedures# or obstetric practice not as a specialist Obstetrician?</b> <small># Cosmetic procedures as defined on page 2</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please carefully consider your professional history. In the last **5 years**, have you changed your type of practice, increased or decreased your gross annual billings by more than 20%, or changed "location" (Country, Australian State, Area Health Service or Hospital). If so, please provide details of the change/s. *If insufficient space, please use the notes section on page 6.*

Previous years/ period	Different specialty or position/title within hospital <i>(if applicable)</i>	Different location (Country, Australian State, Area Health Service or Hospital) <i>(if applicable)</i>	Different gross annual billings# from private practice <i>(if applicable)</i> <small># Gross annual billings as defined on page 2</small>
			\$
			\$
			\$

## Your Indemnity History

Please provide details of your Australian indemnity history. *If insufficient space, please use the notes section on page 6.*

Name of Medical Defence Organisation or Insurer? <i>(Avant, Invivo, MDA National, MIGA, MIPS, Tego or Other)</i>	Year from	Year to	Reasons for leaving <i>(if applicable)</i>

In relation to your previous indemnity in any country:

<b>Have you been refused cover whether by rejection of an application for insurance or membership, cancellation of insurance or membership or not being offered renewal of insurance or membership?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you notified any matters (including claims, incidents, complaints, investigations, inquiries, AHPRA notifications) that have resulted in you having to pay higher than standard premiums for your area of practice?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you had, for any reason, any non-standard terms or conditions placed on your cover?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Premium Payments

How do you prefer to pay your premiums?	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually
For the current premium period, did you receive a payment under the Australian Government's Premium Support Scheme (PSS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

## Current Insurer Feedback

Please let us know if you have any concerns about your current medical indemnity insurer or policy? *If insufficient space, please use the notes section on page 6.*

## Additional Info

Will you be providing us with any further information separately?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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## Finally, how did you hear about Doctors' Choice?

Please indicate all that apply:

<input type="checkbox"/>	<b>Referral/recommendation</b> - Referral business is a great compliment and very much appreciated by Doctors' Choice. We would love to know the name of the person who has recommended our services to you in order to thank them:
<input type="checkbox"/>	<b>Doctors' Choice Website</b> (could you please let us know what prompted your visit):
<input type="checkbox"/>	<b>Doctors' Choice Facebook Page</b> (could you please let us know what prompted your visit)
<input type="checkbox"/>	<b>Direct Contact from Doctors' Choice</b>
<input type="checkbox"/>	<b>Other</b> (please specify)

