Doctors' Choice
Medical Indemnity Advisers

Insurance Information

Please complete and return this Form to Doctors' Choice by email (service@drschoice.com.au) or fax (08 6323 4668). 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).

1. Your Details

Title	**First name**	**Last name** *(also indicate former/maiden name if applicable)*

2. Your Contact Information

Email *(if including more than one, please mark your preferred email address with an asterisk)*	

Residential address	**Primary practice address**	**Other address** *(if applicable)*
Preferred address: ☐ Residential ☐ Practice ☐ Other		

3. Your Practice Information

3.1 Specialty/area of practice e.g. Anaesthesia, Orthopaedic Surgery, Obstetrics *(please indicate all)*:

3.2 Geographical areas in which you currently practice *(please indicate all)*:

☐ ACT ☐ NSW ☐ NT ☐ QLD ☐ SA ☐ VIC ☐ WA ☐ Overseas

3.3 Private practice information

Important note: if all of your work is indemnified by an employer, State or Area Health Authority, please skip to question 3.4 overleaf.

What is the estimate of your current annual private practice billings*?	$_____

**Private practice billings are the total gross billings generated by you from all areas of practice for which you require indemnity (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. In your calculation include Medicare benefits and payments by individuals, the Commonwealth Department of Veterans' Affairs, workers' compensation schemes and third-party and/or vehicle insurers. Also include other healthcare services income received by you e.g. professional fees for writing articles and incentive payments other than those made under the Australian Government's Practice Incentive Program (PIP). Do not include billings/ income from healthcare services for which you have access to indemnity from your employer, State or Area Health Authority.*

How many hour per week (on average) do you work in private practice?	hrs/week
If you commenced private practice in the last 6 years, what was the date you first started private practice? *Leave blank if not applicable.*	_____/_____/_____

3.4 Procedures & practice:	
Do you perform or have you performed procedures or provided services which might be considered outside the scope of your speciality?	☐ Yes ☐ No
Do you undertake or have you undertaken any of the following: prescribing peptide hormones, growth factor analogues, growth factor releasing hormones, anabolic agents or human growth hormone; stem cell therapy; female vaginal rejuvenation; cosmetic labiaplasties; or bio-identical hormone therapy?	☐ Yes ☐ No
Do you perform or have you performed any cosmetic procedures*? **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.*	☐ Yes ☐ No
Are you involved in or have you been involved in obstetric practice not as a specialist Obstetrician?	☐ Yes ☐ No
Do you provide any telehealth* services? **Telehealth means healthcare to or in respect of a patient who is not in the same place as you, which uses any form of technology to enable it to be provided, including video-conferencing, internet and telephone.*	☐ Yes ☐ No
Do you or have you provided healthcare services as part of a clinical trial or research project?	☐ Yes ☐ No
Do you sell any goods or products in the course of providing healthcare services?	☐ Yes ☐ No
Do you/will you perform unpaid volunteer work* at professional sporting events? ** Unpaid volunteer work means work without the expectation of payment apart from reimbursement or receipt of reasonable expenses e.g. travel, meals or accommodation.*	☐ Yes ☐ No
Do you intend to work overseas (paid or voluntary) in the next 2 years?	☐ Yes ☐ No
Are you an owner or part owner of a practice?	☐ Yes ☐ No

3.5 Public patients	
Do you provide or have you in the past provided healthcare services to public patients in a public hospital for which you are not indemnified by your employer, State or Area Health Authority or where you have an option you are exercising to maintain your own medical indemnity insurance for such work?	☐ Yes ☐ No

3.6 Past professional history
In the last 5 years, have you changed your type of practice, increased or decreased your gross annual billings by more than 25%, or changed "location" (Country, Australian State or Area Health Authority)? If so, please provide details of the change/s in the Notes section on page 4.

4. Your Qualifications

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

Are you currently in an accredited training program recognised by the Australian Medical Council (AMC) or completing any AMC assessment or recognition pathway?	☐ Yes ☐ No

5. Your Registration

To save you time, we will obtain your current registration details from the 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?	☐ Yes ☐ No
Are there or have there been any conditions, undertakings, cautions, reprimands or notations placed on your registration or restrictions placed on your practice?	☐ Yes ☐ No

6. Your Indemnity History

6.1 Please provide details of your Australian indemnity history

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

6.2 In relation to your previous indemnity (anywhere in the world):	
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?	☐ Yes ☐ No
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?	☐ Yes ☐ No
Have you had, for any reason, any non-standard terms or conditions placed on your cover?	☐ Yes ☐ No

7. 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 4.*

8. Finally, how did you hear about Doctors' Choice?

Please indicate all that apply:

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

Notes *(if needed)*