



General Practitioner Insurance Information

Please complete and return this Form to Doctors' Choice by email (service@drschoice.com.au) or fax (08 6323 4668). Please 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 <small>(also indicate former/maiden name if applicable)</small>

2. Your Contact Information

Email <small>(if including more than one, please mark your preferred email address with an asterisk)</small>		
Residential address	Primary practice address	Other address <small>(if applicable)</small>
Preferred address: <input type="checkbox"/> Residential <input type="checkbox"/> Practice <input type="checkbox"/> Other		

3. Your Practice Information

3.1 Geographical areas in which you currently practice <small>(please indicate all):</small>	
<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	
3.2 Do you practise in any areas 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
3.3 Private practice information	
Important note: if <u>all</u> 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 <u>annual</u> private practice billings*?	\$ _____
<small>*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 <u>not</u> include billings/income from healthcare services for which you have access to indemnity from your employer, State or Area Health Authority.</small>	
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? <small>Leave blank if not applicable.</small>	____/____/____

3.4 Procedures & practice	
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? (Please disregard emergency assistance situations when answering this question.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Terminations of pregnancy - Do you require cover for: a) medical terminations of pregnancy? b) surgical terminations of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <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
Cosmetic procedures - Do you perform 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you provide any telehealth* services? <i>*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.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you perform procedures or provide services which might be considered outside the normal scope of your specialty? If yes, please provide details in the notes section on page 4.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or have you provided healthcare services as part of a clinical trial or research project for which you are not indemnified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sell any goods or products in the course of providing healthcare services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/will you perform unpaid volunteer work* at professional sporting events? <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
Do you intend to work overseas (paid or voluntary) in the next 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you an owner or part owner of a practice?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <u>not</u> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

3.6 Past professional history	
In the <u>last 5 years</u> , 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 any training program? If so, please provide details in the Notes section on page 4.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there or have there been any conditions, undertakings, cautions, reprimands or notations placed on your registration or restrictions placed on your practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Your Indemnity History

6.1 Please provide details of your Australian indemnity history

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>

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had, for any reason, any non-standard terms or conditions placed on your cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Current Insurer Feedback

Do you have any concerns about your current medical indemnity insurer or policy? *If so, please use the notes section on page 4.*

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

Please indicate all that apply:

<input type="checkbox"/>	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 who has recommended our services to you in order to thank them:
<input type="checkbox"/>	Doctors' Choice Website (please let us know what prompted your visit, in our Notes section)
<input type="checkbox"/>	Doctors' Choice Facebook Page (please let us know what prompted your visit, in our Notes section)
<input type="checkbox"/>	Direct Contact from Doctors' Choice
<input type="checkbox"/>	Other (please specify in our Notes section)

