



Invivo Medical Pty Ltd  
ABN 85 108 316 123

# Rewarding good practice with lower premiums

Obtain a quote from Invivo  
to find out why it's worth  
the switch today.

- 1 Complete the proposal form found on the following pages
- 2 Mail it in the enclosed reply paid envelope
- 3 We'll respond within 3 business days

Or you can apply online at:  
[www.invivo.com.au](http://www.invivo.com.au)

1800 103 779



# New Business Proposal Form

## 1 Your Details.

|                      |                      |                      |                       |
|----------------------|----------------------|----------------------|-----------------------|
| <b>Surname</b>       | <b>Title</b>         | <b>First Name</b>    | <b>Middle Name(s)</b> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>  |

|   |  |
|---|--|
| <b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female | <b>Have you ever changed your name?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>DOB (DD/MM/YY)</b>   | <b>If so please provide former name(s).</b>  |
| <input type="text"/>  | <input type="text"/>   |

|                        |                         |                      |
|------------------------|-------------------------|----------------------|
| <b>Contact Numbers</b> | <b>Facsimile Number</b> | <b>Mobile Number</b> |
| <b>Phone Number</b>    | <input type="text"/>    | <input type="text"/> |
| <input type="text"/>   |                         |                      |

**Postal Address**

|                      |                        |
|----------------------|------------------------|
| <b>Email Address</b> | <b>Provider Number</b> |
| <input type="text"/> | <input type="text"/>   |

## 2 Practice Details.

|                              |   |
|------------------------------|---|
| <b>Name Of Your Practice</b> | <b>Name Of Your Own Practice Company (if different)</b> |
| <input type="text"/>         | <input type="text"/>                                    |

**Street Address (if different to postal above)**

Staff employed directly by you or through a practice company solely owned by you.  
(Please insert number of employees in the respective activities, in full-time equivalents.)

|   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Clerical/reception   | <input type="checkbox"/> Midwife     | <input type="checkbox"/> Nurse<br><small>(please specify duties in section 20)</small> |
| <input type="checkbox"/> Occupational or Physical Therapist                                 | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Orthoptist  |
| <input type="checkbox"/> Technician<br><small>(please specify duties in section 20)</small> |                                      |  |
| <input type="checkbox"/> Other (please provide description):                                | <input type="text"/>                 |  |

**3** Details of hospitals where you have privileges, facilities you use and any positions held.

| Hospital Name | State | Facilities Used | Positions Held |
|---------------|-------|-----------------|----------------|
| 1.   _____    | _____ | _____           | _____          |
| 2.   _____    | _____ | _____           | _____          |
| 3.   _____    | _____ | _____           | _____          |
| 4.   _____    | _____ | _____           | _____          |

**4** Details of your Education/Training/Qualifications.

Please provide full details of all medical qualifications including college fellowship(s).

| Qualifications | University/Institution/College | Country (if not Australia) | Year completed |
|----------------|--------------------------------|----------------------------|----------------|
| _____          | _____                          | _____                      | _____          |
| _____          | _____                          | _____                      | _____          |
| _____          | _____                          | _____                      | _____          |
| _____          | _____                          | _____                      | _____          |

Please provide details of membership(s) of societies and other medical or professional association(s).

\_\_\_\_\_

\_\_\_\_\_

Have you complied with the requirements of your professional association(s) for Continual Professional Development in the past 12 months? If NO please provide an explanation.  Yes  No

\_\_\_\_\_

**5** Registration.

**A** In what year were you first registered in Australia as a Medical Practitioner? (YYYY)

**B** Have you, for any period after your first registration, not been registered as a Medical Practitioner or had your registration suspended? If YES please provide an explanation.  Yes  No

| From  | To    | Reason |
|-------|-------|--------|
| _____ | _____ | _____  |

**C** In which of the following Australian jurisdictions are you currently registered as a Medical Practitioner?

ACT  NSW  NT  QLD  SA  TAS  VIC  WA

**D** Are there any special conditions placed on your current registration or have you had any restrictions or special conditions placed on a previous registration? If YES please supply copy of documentation.  Yes  No

**6** Details of your Medical Practice.

**A** Estimated total hours spent in practice per week.

|                           | Public Patient Hours | Private Patient Hours | TOTAL PATIENT HOURS  |
|---------------------------|----------------------|-----------------------|----------------------|
| Consulting/Non-procedural | <input type="text"/> | <input type="text"/>  |                      |
| Surgical/Procedural       | <input type="text"/> | <input type="text"/>  |                      |
| Admin/Research/Other      | <input type="text"/> | <input type="text"/>  |                      |
| <b>Subtotal</b>           | <input type="text"/> | <input type="text"/>  | <input type="text"/> |

**B** Do you perform. Please tick the appropriate box.

Yes / No

- Obstetric procedures**, not constituting major surgery. Caesarean sections are considered MAJOR surgery.
- No Surgery** other than incisions of boils and superficial abscess, suturing of skin or superficial fascia.
- Minor Surgery**. Assisting at major surgery either on your own patient or at the invitation of the primary surgeon, surgery confined to the skin and integument (excluding cosmetic surgery) and closed reduction of fractures, either under local, regional or general anaesthesia.
- Major Surgery**. All operations, whether under local, regional or general anaesthesia, upon or within any body cavity, the cranium, pelvis and perineum, all tumour removal whether benign or malignant, compound fractures, open reduction and fixation of fractures, amputations, removal of any gland or organ, plastic surgery, tonsillectomy and adenoidectomy.
- Workers Compensation**. Consultations for the treatment of injuries or conditions for patients who are receiving or applying for workers compensation benefits.  
 % If yes, what percentage of your practice is related to this work?
- % **Private Paediatrics** expressed as a percentage of TOTAL PATIENT HOURS (please refer to question 6A).

**C** Based on the information provided above (question 6B), please select your primary specialties.

Please note: Some fields require you to provide additional information (express percentages based on hours of practice).

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>Anaesthesia</b>   | <input type="checkbox"/> <b>Gerontology</b>   | <input type="checkbox"/> <b>Otolaryngology</b>  |
| <input type="checkbox"/> <b>Bariatric Surgery</b>   | <input type="checkbox"/> <b>Gynaecology</b>   | <input type="checkbox"/> <b>Paediatrics</b>   |
| <input type="checkbox"/> <b>Cardiology</b><br><input type="text"/> % Interventional       | <input type="checkbox"/> <b>Haematology</b>   | <input type="checkbox"/> <b>Palliative Care</b>   |
| <input type="checkbox"/> <b>Cardiothoracic Surgery</b>                                    | <input type="checkbox"/> <b>Hand Surgery</b>  | <input type="checkbox"/> <b>Pathology</b>   |
| <input type="checkbox"/> <b>Colorectal Surgery</b>  | <input type="checkbox"/> <b>Head &amp; Neck Surgery</b>   | <input type="checkbox"/> <b>Physician</b>   |
| <input type="checkbox"/> <b>Cosmetic Physician</b>  | <input type="checkbox"/> <b>Hepatobiliary Surgery</b>   | <input type="checkbox"/> <b>Plastic &amp; Reconstructive Surgery</b><br><input type="text"/> % Cosmetic |
| <input type="checkbox"/> <b>Dermatology</b><br><input type="text"/> % Cosmetic Procedures | <input type="checkbox"/> <b>Immunology</b>  | <input type="checkbox"/> <b>Psychiatry</b>  |
| <input type="checkbox"/> <b>Emergency Medicine</b>  | <input type="checkbox"/> <b>Intensive Care</b>  | <input type="checkbox"/> <b>Radiation Oncology</b>  |
| <input type="checkbox"/> <b>Endocrine Surgery</b>   | <input type="checkbox"/> <b>Medico-Legal</b>  | <input type="checkbox"/> <b>Radiology Diagnostic</b>  |
| <input type="checkbox"/> <b>Endocrinology</b>   | <input type="checkbox"/> <b>Neurology</b>   | <input type="checkbox"/> <b>Radiology Diagnostic &amp; Therapy</b>                                      |
| <input type="checkbox"/> <b>Fertility</b>   | <input type="checkbox"/> <b>Neurosurgery</b>  | <input type="checkbox"/> <b>Rehabilitation Physician</b>  |
| <input type="checkbox"/> <b>Gastroenterology</b>  | <input type="checkbox"/> <b>Nuclear Medicine</b>  | <input type="checkbox"/> <b>Rheumatology</b>  |
| <input type="checkbox"/> <b>Gastrointestinal Surgery</b>                                  | <input type="checkbox"/> <b>Obstetrics &amp; Gynaecology</b><br><input type="text"/> % Obstetrics | <input type="checkbox"/> <b>Respiratory Physician</b>   |
| <input type="checkbox"/> <b>General Practice</b>  | <input type="checkbox"/> <b>Oncology</b>  | <input type="checkbox"/> <b>Sports Medicine</b>   |
| <input type="checkbox"/> <b>General Surgery</b>   | <input type="checkbox"/> <b>Ophthalmology</b>   | <input type="checkbox"/> <b>Urology</b>   |
|   | <input type="checkbox"/> <b>Orthopaedic Surgery</b>   | <input type="checkbox"/> <b>Vascular Surgery</b>  |
| <input type="checkbox"/> <b>Other:</b> <input type="text"/>                               |   |   |

**D** In the past 10 years, have you practised in a field or specialty other than as stated above?  
If YES please describe these changes.

Yes  No

**General Questions.**

**7** Do you perform any procedures or supply any services that are or may be considered outside what is normal in your field or specialty? If YES please provide details.  Yes  No

**8** Have you or anyone in your employ ever been subject to any investigation by or faced any form of disciplinary action by a state medical registration board? If YES please provide details.  Yes  No

**9** Has your membership (or that of anyone you employ) in any medical college or association or any other professional organisation ever been denied, revoked, suspended or had limitations placed on it? If YES please provide details.  Yes  No

**10** Have you or anyone in your employ ever had a proposal for professional indemnity insurance refused by any previous Insurer or MDO or had an existing policy cancelled or issued with special terms, such as an excess, premium loading or practice restrictions, on the cover? If YES please provide details.  Yes  No

**11** Have you or anyone in your employ ever had an application for hospital privileges denied (other than as a result of a lack of availability of facilities) or granted with restrictions or conditions limiting your services? If YES please provide details.  Yes  No

**12** Have you or anyone in your employ ever been charged with, or accused or convicted of an act in violation of any law or ordinance, other than parking or speeding infringements? If YES please provide details.  Yes  No

**13** Do you have any contractual obligation requiring you to treat patients at an Accident / Emergency facility? If YES please provide details.  Yes  No

**14** Do you own, operate or have any interest (financial or other) in a Hospital, Medical Centre or other facility providing Medical Services? If YES please provide details.  Yes  No

**15** Do you engage in or perform any surgical procedures in your professional suite or any unlicensed facility? If YES please provide details of the procedures and complete (a) (b) & (c), below  Yes  No

(a) Are any of the medical procedures above performed under general anaesthetic?  
If you answered YES to (a) please respond to the following:  Yes  No

(b) Is the general anaesthetic administered by a qualified anaesthetist?  Yes  No

(c) Do you follow the recommendation of ANZCA T2 (2000) for administering anaesthetic outside operating suites?  Yes  No

**16** Do you participate in, provide services to or have an association with any clinical trials, for which you require indemnity under this policy?  Yes  No

**17** Details of your current and previous insurers.

|         | Name of insurer | Date Cover Ceased | Retro active date shown on policy |
|---------|-----------------|-------------------|-----------------------------------|
| Current |                 |                   |                                   |
| Prior   |                 |                   |                                   |

(Please use a separate sheet of paper to report any details for which there is insufficient space.)

**18** Prior Claims, Incidents or Health Care Complaints or Disciplinary Action.

Have you or anyone in your employ ever had any claims made against you or your employees arising from the provision of medical services by you or your employees, whether finalised or not, in the past 10 years? If YES please provide details of each action and whether the allegation resulted in a verdict against you or your employees.

(Your previous insurers can provide you a printout upon request if you are uncertain.)

Yes  No

| Date of Matter     | Insurer | Claimant Name | Actual or expected quantum of claim including defence costs | Notified to the Insurer? (Yes/No) |
|--------------------|---------|---------------|---|-----------------------------------|
| <b>A</b>           |         |               | \$  |                                   |
| Brief Description: |         |               |   |                                   |
| <b>B</b>           |         |               | \$  |                                   |
| Brief Description: |         |               |   |                                   |
| <b>C</b>           |         |               | \$  |                                   |
| Brief Description: |         |               |   |                                   |

(Please use a separate sheet of paper to report any details or claims for which there is insufficient space.)

Are you or anyone in your employ (AFTER ENQUIRING of your employee/s) aware of any threat of a claim, incident or other circumstance which might give rise to a claim against you or anyone in your employ arising from the provision of medical services in the past 10 years by you or your employees which you have NOT disclosed above?

Yes  No

| Date of Matter     | Insurer | Claimant Name | Insurer's estimate of potential liability including defence costs | Notified to the Insurer? (Yes/No) |
|--------------------|---------|---------------|---|-----------------------------------|
| <b>A</b>           |         |               | \$  |                                   |
| Brief Description: |         |               |   |                                   |
| <b>B</b>           |         |               | \$  |                                   |
| Brief Description: |         |               |   |                                   |
| <b>C</b>           |         |               | \$  |                                   |
| Brief Description: |         |               |   |                                   |

(Please use a separate sheet of paper to report any details or claims for which there is insufficient space.)

Have any requests or subpoena's for patient information been received from an organisation investigating health care related complaints or legal representative of a patient in respect of work you have performed that may give rise to a claim?

Yes  No

Brief Description:

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## IMPORTANT NOTICE

This is a proposal for a Professional Indemnity Insurance Policy underwritten by Invivo Medical Pty Ltd (us) on behalf of QBE Insurance (Australia) Ltd (the insurer). It is important that all information contained in this proposal is accurate and complete as this document will form the basis of the insurance contract between you and the insurer. In completing this proposal, 'you' means the proposed insured and employees of the insured. Please answer each question fully. Where there is not sufficient room, please provide your answer on a separate page. Failure to disclose all material information that is likely to influence the acceptance of the risk or the terms applied could invalidate the insurance. If you have any doubt as to whether any information is material, it should be disclosed.

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(Pursuant to the provisions of the Insurance Contracts Act 1984)

### 1. DISCLOSURE OF RELEVANT FACTS

#### Your duty of disclosure

Before you enter into a contract of general insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter which you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of insurance.

Your duty, however, does not require disclosure of a matter:

- o that diminishes the risk to be undertaken by the insurer
- o that is common knowledge
- o that the insurer knows or, in the ordinary course of business as an insurer, ought to know
- o as to which compliance with your duty is waived by the insurer.

#### Non-Disclosure

If you fail to comply with your duty of disclosure, the insurer may be entitled to reduce its liability under the contract in respect of a claim or may cancel the contract. If your non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning.

#### Comment

The requirement of full and frank disclosure is of the utmost importance with this type of insurance. This is particularly the case in respect of anything which may be relevant to the risk for which you seek cover (e.g. claims, whether founded or unfounded), or to the magnitude of the risk.

### 2. SUBROGATION

The insurer has a right under the policy to take over all of your rights of recovery with respect to a claim and to pursue actions against third parties in your name even if a claim has not actually been paid. If you surrender any right or settle any claim for contribution, indemnity or recovery without the prior written consent of the insurer, then the insurer may be entitled to reduce its liability under the contract of insurance.

### 3. CLAIMS MADE POLICY

This declaration is for a "claims made and notified" policy of insurance. This means that the policy covers you for claims made against you and notified to us during the period of cover.

This policy does not provide cover in relation to:

- o acts, errors or omissions actually or allegedly committed prior to the retroactive date of the policy (if such a date is specified);
- o claims made after the expiry of the period of cover even though the event giving rise to the claim may have occurred during the period of cover;
- o claims notified or arising out of facts or circumstances notified (or which ought reasonably to have been notified) under any previous policy;
- o claims made, threatened or intimated against you prior to the commencement of the period of cover;
- o facts or circumstances of which you first became aware prior to the period of cover, and which you knew or ought reasonably to have known had the potential to give rise to a claim under this policy;
- o claims arising out of circumstances noted on the proposal form for the current period of cover or on any previous proposal form.

#### Section 40(3) of the Insurance Contracts Act

Where you give notice in writing to us of any facts that might give rise to a claim against you as soon as reasonably practicable after you become aware of those facts but before the expiry of the period of cover, you may have rights under Section 40(3) of the Insurance Contracts Act 1984 to be indemnified in respect of any claim subsequently made against you arising from those facts notwithstanding that the claim is made after the expiry of the period of cover. Any such rights arise under the legislation only. The terms of the policy and the effect of the policy are that you are not covered for claims made against you after the expiry of the period of cover.