western
Rethink Insurance

PROFESSIONAL INDEMNITY FORM

OHSA RELATED PROFESSIONALS (Short Form)

PROPOSER DETAILS

Insured Name:	
Title of Insured / Practice:	
Tel No:	Association Reg No:
Fax No:	Vat Registration No:
Email Address:	Business Reg / ID No:
Postal Address:	
Present Legal Constitution (Mark relevant box below)	
Sole Practitioner ☐ Partnership ☐ Incorporated ☐ Limited ☐ Close Corporation ☐	

ADDRESS OF PRACTICE

Principal Office:	Address:	Partner/Principal in Charge:

DATE OF COMMENCEMENT OF PRACTICE

As Currently Constituted:	As Initially Established:

ASSOCIATION MEMBERSHIP DETAILS

List membership details of any industry or related association of which the operating entity is a member:

NAMES AND QUALIFICATIONS OF PRINCIPALS

1. In the case of Partnerships - Partners
2. In the case of Incorporated - Directors
3. In the case of Ltd Companies - Professionally qualified Directors and Employees
4. In the case of Close Corporations - Members

Name:	Qualification:	Date Qualified:	How long practicing in practice:

Have any claims ever been made against the proposed Insured / Partners / Directors / Members or Employees? Yes ☐ No ☐

If yes; please provide full details: _____

Are you at present or have you in the past been insured? Yes ☐ No ☐

If yes; please provide the following details:

Name of Insurers:		
Indemnity Limit: R/N$	Excess of: R/N$	Each and every claim
Date of Expiry of coverage:		

Is Indemnity to apply to any Principal who has left / retired / died? Yes ☐ No ☐

For the type of insurance now being proposed, has any Insurer ever:

1. Declined Proposal or renewal for this Proactive or any Partner / Principal? Yes ☐ No ☐
2. Required an increased premium or imposed special terms? Yes ☐ No ☐
3. Cancelled any insurance? Yes ☐ No ☐
4. Does this practice undertake any work outside of RSA? Yes ☐ No ☐

If Yes to any of the above, please provide full details: _____

DETAILED BUSINESS DESCRIPTION

FEE INCOME - AS AT THE PRACTICE'S FINANCIAL YEAR END

Please provide gross fees received during the past five years:

Year:	Gross Fees:	Year:	Gross Fees:
Current Year	R/N$	Next Year	R/N$

QUOTATION REQUIRED

Limit of Indemnity:	Excess:
Alternate Limit 1:	Excess:
Alternate Limit 2:	Excess:

CATEGORY - Please indicate which one is applicable

PrCHSA	Yes ☐	No ☐
CHSM	Yes ☐	No ☐
CHSO	Yes ☐	No ☐
Trainee	Yes ☐	No ☐

DECLARATION

I/We hereby declare that the above statements and particulars contained in this Proposal are true and complete at the present time. Otherwise than as stated, I/We have no reason to anticipate any claim under the insurance now being requested.

I/We agree that this proposal together with any other information supplied by me / us, shall form the basis of any contract of insurance effected thereon, and shall be incorporated therein.

I/We undertake to inform the company of any material alteration to these facts, whether occurring before or after completion of the contract of insurance

Signed at: _____on _____ /_____ / 20 _____ by _____

Signature: _____

Witness: _____ Capacity: _____ Tel No:_____

Signature: _____

PLEASE NOTE: If this proposal is being completed for the renewal of an existing policy, please remember that cover lapses automatically at midnight on the last day of your expiring policy, unless a written extension of no longer than 10 days is requested and has been granted from underwriters, or renewal terms have been accepted.

CONTACT INFORMATION

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