Malpractice Professional Indemnity Claim Form

NOTIFICATION OF CIRCUMSTANCES OUT OF WHICH A CLAIM MIGHT ARISE

Please do not include any statement or comment on this form which could be construed as an admission of fault.

Please attach any supplementary information and relevant correspondence.

Insured's details

1. Name(s) of the Insured

2. Insured's address

Postcode

3. Contact name

Telephone no.

4. Email address

5. Policy number

6. Period of insurance from D D / M M / Y Y to D D / M M / Y Y

7. Are you registered for GST purposes? No ☐ Yes ☐ What is your ABN?

8. **a.** Are you entitled to an Input Tax Credit on 100% of the GST paid on your insurance premium? No ☐ Yes ☐

b. Is your entitlement 100%? Yes ☐ No ☐ Please specify your percentage entitlement %

Claim details

1. Name of patient

Age of patient Sex of patient Marital status

2. Dependent details

3. Date patient admitted/treated D D / M M / Y Y

Inpatient? Yes ☐ No ☐

Outpatient? Yes ☐ No ☐

4. Diagnosis before incident?

5. What treatment was given to patient?

6. Date of incident/treatment out of which an allegation of malpractice may arise

D D / M M / Y Y

7. What allegations of malpractice may be made? ☐ Incident ☐ Complaint ☐ Complications (Indicate appropriate box)

8. Details of injuries sustained

Diagnosis

Prognosis

Residual diagnosis

9. Details of other parties involved in treatment (i.e. doctors, nurses, etc.)

10. Have you received a demand for compensation?

No ☐ ▶ Go to Q11.

Yes ☐ ▶ **a.** was it a written demand? No ☐ Yes ☐ ▶ Please attach copy of the demand and go to Q11.

b. was it a verbal demand? No ☐ Yes ☐ ▶ Please complete the following:

c. Date of verbal demand D D / M M / Y Y

d. Name of person making the verbal demand

e. Name of person who received the verbal demand

f. Allegations made

g. Compensation sought

11. Have you received a request to attend an Official Enquiry into the circumstances notified in this report?

No ☐ Yes ☐ ▶ Please attach copy of the request.

Declaration

I declare that I am the person completing and executing this form and am authorised by the insured/policyholder to do so and that to the best of my knowledge and belief the information supplied by me herein is true and correct and I have not withheld any relevant information.

I agree that, by submitting this form, the personal information I provide to Plus Indemnity in this form or otherwise may be collected, held, used and disclosed in the manner set out in the Plus Indemnity Privacy Policy found at http://www.plusindemnity.au/privacy-policy, including for processing this claim.

Signature of the insured or person with authority to sign for and on behalf of company or partnership

Date

D D / M M / Y Y

On completion of this form, please print and sign.
When ready, please return the form to Plus Indemnity Claims via mail or e-mail.

Pacific Indemnity Underwriting Solutions Pty Ltd trading as Plus Indemnity
PO Box 2 Collins Street West, Melbourne 8007
Email claims@plusindemnity.au

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