

FIRST AID PROVIDERS & EMERGENCY MEDICAL TECHNICIANS PROFESSIONAL INDEMNITY INSURANCE PROPOSAL FORM

IMPORTANT FACTS RELATING TO THIS PROPOSAL FORM

The Purpose of this Proposal Form is to set out all relevant information for your adviser to submit on your behalf to the insurer(s). Under the Insurance Contracts Act 1984, you are under a duty to make full disclosure in this Proposal Form as follows:

Your Duty of Disclosure

Before you enter into a contract of general insurance with an insurer, you have a duty, under the Insurance Contract Act 1984 to disclose to the insurer every matter that 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 general insurance.

Your duty however does not require disclosure of matters –

- that diminish the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows, or in the ordinary course of their business, ought to know;
- 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 opportunity of voiding the contract from its beginning. There are other matters of which you should be aware in relation to the proposed professional indemnity insurance, as follows:

Claims Made

The proposed Professional Indemnity insurance policy is claims made and notified insurance i.e. it only covers claims made against you and notified to the insurers during the period of insurance. However, provided that you give the insurers notice of any circumstances that may give rise to a claim against you immediately you become aware of these facts and during the period of insurance, then this insurance will respond notwithstanding that no claim has actually been made against you during the period of insurance.

Retroactive Liability

There is provision in the proposed Professional Indemnity insurance policy for the operation of a retroactive date. Claims which subsequently arise from circumstances which occurred prior to the retroactive date are excluded.

Liability Assumed Under Agreement

The proposed Professional Indemnity insurance policy excluded liability arising out of any obligation assumed by way of warranty, guarantee or indemnity to the extent that such liability exceeds the liability which would have been incurred in the absence of such obligation.

Utmost Good Faith

A contract of insurance is based on the utmost good faith requiring the insurers and the Policyholder(s) to act towards each other with utmost good faith in respect of any matter arising in relation to the insurance.

Privacy

We are committed to protecting your privacy. To provide you with our services, which include negotiation and acquisition of insurance, we need to obtain certain information from you and pass it on to the third parties who are necessary to assist us in providing these services to you. These include insurers, accountants, lawyers and other advisers. We use the information you provide to advise about and assist with your insurance needs. We do not trade, rent or sell your information.

For further information about our Privacy Policy, ask for a copy or visit our website - www.optimuminsurance.com.au

Optimum Service from Quote to Claim

Optimum Insurance Services is a Corporate Authorised Representative of
Insurance Advisernet Australia Pty Limited AFSL 240549 AR No. 291220

APPLICANT DETAILS

Policyholder	Sole Traders - list your full name and trading name (if applicable) Companies – list all companies including all subsidiary companies and trading names		
	<div></div>		
	ABN	<div></div>	
Former Subsidiary(s)	Please list any former subsidiaries of the Policyholder		
	<div></div>		
Office Address	<div></div>		
	Postcode	<div></div>	
Branch Address (if applicable)	<div></div>		
	Postcode	<div></div>	
Date Commenced Business	<div></div>		
Contact Person	<div></div>		
Phone	<div></div>	Fax	<div></div>
Email	<div></div>	Website	<div></div>

FINANCIAL DETAILS

	Last 12 months	Estimate Next 12 months
1. Total Gross Turnover		
Australia	<div>\$</div>	<div>\$</div>
USA or Canada	<div>\$</div>	<div>\$</div>
Elsewhere, excluding USA & Canada	<div>\$</div>	<div>\$</div>
TOTAL	<div>\$</div>	<div>\$</div>
2. Annual Gross Wages	<div>\$</div>	<div>\$</div>
3. Fees paid to Sub-Consultants *	<div>\$</div>	<div>\$</div>

* Sub-consultants will be covered under extension 7.7 'Indemnity to contractors' of this policy, provided that the conditions of that extension are met.

4. Please state the percentage of Your activities (based on income) applicable to each State.

ACT	NSW	NT	QLD	SA	TAS	VIC	WA	O/SEAS	TOTAL
<div></div> %	<div></div> %	<div></div> %	<div></div> %	<div></div> %	<div></div> %	<div></div> %	<div></div> %	<div></div> %	<div>100 %</div>

BUSINESS INFORMATION

5. Please indicate the percentage breakdown of your gross professional income derived from the following activities performed by professionally qualified staff (both fees and commissions) according to your business activities including any changes to these activities in the next 12 months.

Business Activity Description	Percentage of Income
(i) First Aid Training Services - Registered Training Organisation (RTO)	<input type="text"/> %
(ii) Non-Emergency Patient Transport care services by qualified first aid providers or paramedic	<input type="text"/> %
(iii) Event Paramedical Services by qualified first aid providers or paramedic	<input type="text"/> %
(iv) Private Emergency Transport Care (Ambulance officer)	<input type="text"/> %
(v) AREMT Assessor	<input type="text"/> %
(vi) Occupational Health & Safety Consultant	<input type="text"/> %
(vii) Product Sales	<input type="text"/> %
Other (please provide full details below and/or attach a separate addendum)	<input type="text"/> %
<input type="text"/>	
Total	100 %

6. Please indicate which of the following industry associations you belong to?

<input type="checkbox"/> ECPA				
<input type="checkbox"/> AREMT - Please advise membership category	First Responder <input type="checkbox"/>	EMT Basic <input type="checkbox"/>	EMT Intermediate <input type="checkbox"/>	
<input type="checkbox"/> ARC	EMT Paramedic <input type="checkbox"/>	EMT Intensive Care <input type="checkbox"/>	AREMT Assessor <input type="checkbox"/>	
<input type="checkbox"/> Other - Please provide details:				

7. Employees Numbers	Category	Full-Time	Part-Time
	Directors / Principals	<input type="text"/>	<input type="text"/>
	Professional Qualified Staff	<input type="text"/>	<input type="text"/>
	Other Qualified Staff	<input type="text"/>	<input type="text"/>
	Sales Staff	<input type="text"/>	<input type="text"/>
	Administration	<input type="text"/>	<input type="text"/>
	Other Staff (please specify)	<input type="text"/>	<input type="text"/>
	<input type="text"/>		
	Total	<input type="text"/>	<input type="text"/>

8. a) Names and details of all partners/ principals/directors

Full Name	Age	Qualification	Years Practicing Current Practice	Years Practicing Previous Practice
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

9. a) Has the Company name ever changed? Yes ☐ No ☐
- b) Has the business activities ever changed? Yes ☐ No ☐
- c) Has any other business or practice amalgamated or merged with you? Yes ☐ No ☐
- d) Have you purchased any other business or practice? Yes ☐ No ☐
- e) Are you or any Partner/Director associated (financially or otherwise) with any other Business/Practice? Yes ☐ No ☐
- If YES to any of the above, please provide details.

10. Do you envisage any major changes in your activities during the next 12 months? If YES, please provide details. Yes ☐ No ☐

11. Do you perform work located outside Australia or work for clients located overseas? If Yes, please advise which country(s) are clients located? Yes ☐ No ☐

12. Do you always confirm verbal reports and advice in writing? Yes ☐ No ☐
If NO, how do you substantiate such verbal reports or advice?

13. Do you apply the principle of separation of duties, as much as practicable, in order to minimize the incidence of fraud and dishonesty by employees? Yes ☐ No ☐

14. Are hold-harmless agreements ever entered into or any legal right or entitlement that you may have against such consultants, sub-contractors or agents ever waived? If Yes, please provide full details, including copies of any such agreements. Yes ☐ No ☐

COVER OPTIONS

15. a) Do you have current Professional Indemnity Insurance in force? If YES, please advise the following and provide a copy of your current certificate of insurance. Yes ☐ No ☐

Name of Insurer		Policy Number	
Limit of Indemnity		Retroactive Date	
Renewal Date		Excess	

- b) What Indemnity Limit do you require for your Professional Indemnity Insurance?
- ☐ \$1,000,000 ☐ \$2,000,000 ☐ \$5,000,000 ☐ \$10,000,000 ☐ Other \$

- c) Do you also require a quotation for Public & Products Liability Insurance? Yes ☐ No ☐
- ☐ \$5,000,000 ☐ \$10,000,000 ☐ \$15,000,000 ☐ \$20,000,000 ☐ Other \$

GENERAL / CLAIMS DETAILS

16. Has any insurer, in respect of the risks to which this proposal relates, ever:

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| a) Declined a proposal, refused renewal or terminated an insurance contract? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| b) Required an increased premium or imposed special conditions? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| c) Declined an insurance claim by the Insured(s) or reduced its liability to pay an insurance claim in full (other than by the application of an Excess)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If yes to any of the above, please give details.

- 17.** a) Has any claim been made against the Insured(s) or any principal, partner, director, consultant or employee in respect of the risks which this proposal relates? Yes ☐ No ☐
- b) Has the Insured(s) or any principal/partner/director/ consultant or employee incurred any other loss or expense which might be within the terms of cover? Yes ☐ No ☐

If yes in either case, please provide details.

Date of Claim or Loss	Brief details of Claim or Loss	Cost(if any) of Claim Paid or Incurred	Estimated Outstanding Loss
		\$	\$
		\$	\$
		\$	\$

What action has been taken to prevent a recurrence of the situation which gave rise to each claim or loss?

18. Is any principal, director, partner, consultant or employee, after enquiry, aware of any circumstances which might:

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| a) Give rise to a claim against the Insured(s) or his / her predecessors in business or any of the present or former partners, principals, directors, consultants or employees? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| b) Result in the Insured(s) or his / her predecessors in business or any of the present or former partners, principals, directors, consultants or employees incurring any losses or expenses which might be within the terms of this cover? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| c) Otherwise effect the Insurance Company's consideration of this Insurance? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If yes to any of the above, please give details.

It is agreed that if such facts, circumstances or situations exist, whether or not disclosed, any claim arising from them is excluded from this proposed coverage.

DECLARATION

I/We the undersigned duly authorised person(s) declare that:

- I am/we are authorised by each of the Insured(s)s to sign this Proposal Form; and
- the above statements are correct, true and complete; and
- no information material to this Proposal Form has been withheld; and
- I/we have read the important facts which you have put before me/us and I/we understand the advice given in relation to the duty of disclosure; and
- I/we have diligently made all necessary and detailed enquiries in order to comply with the duty of disclosure; and
- I/we understand that no insurance is in force until such time as the insurer has confirmed acceptance of the proposed insurance; and
- I/We undertake to inform the insurer of any material alteration to these facts occurring before completion of the contract of insurance; and
- I/we acknowledge that the Insurer relies on the information and representations in this Proposal Form and otherwise made by me/us in relation to this insurance.

Signature	<input type="text"/>
Full Name	<input type="text"/>
Position	<input type="text"/>
Company	<input type="text"/>
Date	<input type="text"/>

Return to Address: Suite 1.01, Level 1, 27 Belgrave Street, MANLY NSW 2095

Fax: 1300 732 225

Email: service@optimuminsurance.com.au