

Instructions for completing this Supplementary Proposal Form

- 1. 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 are in any doubt as to whether any information is material, it should be disclosed.
2. Where the space provided is insufficient for your replies, please provide these separately and attach to this Supplementary Proposal Form.
3. Reference to Insured in this Supplementary Proposal Form means:
- the entity or entities named in question 1
- the past and/or present employees or principals of the entity or entities; and
- the directors of the entity or entities and all subsidiary entities for whom cover is required.

1. Name of all entities to be insured [text box]

2. Date that the Proposal Form to which is this is a Supplementary Proposal Form was signed and dated [/ /]

3. Is the Insured approved as a provider of aged care under the Aged Care Act 1997? Yes [] No []

4. Does the Insured currently meet the accreditation requirements of the Aged Care Act 1997? Yes [] No []

5. Has the Insured's accreditation under the Aged Care Act 1997 ever been declined, suspended or cancelled? Yes [] No []
If Yes, please give details.

[text box]

[text box]

6. Has the Insured ever had sanctions imposed under the Aged Care Act 1997? Yes [] No []
If Yes, please give details and date of and reasons for sanction.

[text box]

[text box]

7. Please state the number of beds/units maintained by Insured in the following categories:

a) High care (Nursing Home Beds) Category 1-4 [text box]

b) Low care (Hostel beds) Category 5-8 [text box]

c) Independent Living Units (Including Self Care Units) [text box]

d) Other (intellectual disability, accident victims) [text box]

8. State number of employees in each of the following classifications:

a) Registered Nurses [text box]

b) Enrolled Nurses [text box]

c) Nursing assistants/personal care assistants [text box]

d) Clerical assistants [text box]

e) Pharmacists [text box]

f) Other (please specify) [text box]

[text box]

TOTAL [text box]

9. Does the Insured maintain accurate descriptive records of all medical services rendered?

Yes

No

10. Does the Insured's facility accept young people with disabilities?

Yes

No

Declaration

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

- i. I am/we are authorised by each of the Insured to sign this Supplementary Proposal Form; and
- ii. the above statements are correct, true and complete; and
- iii. no information material to this Supplementary Proposal Form has been withheld; and
- iv. I/we have read the **important facts** which you have put before me/us in the Professional Indemnity Proposal Form and I/we understand the advice given in relation to the **duty of disclosure**; and
- v. I/we have diligently made all necessary and detailed enquiries in order to comply with the **duty of disclosure**; and
- vi. I/we understand that no insurance is in force until such time as the insurer has confirmed acceptance of the proposed insurance; and
- vii. I/we undertake to inform the insurer of any material alteration to these facts occurring before completion of the contract of insurance; and
- viii. I/we acknowledge that the Insurer relies on the information and representations in this Supplementary Proposal Form and otherwise made by me/us in relation to this insurance; and
- ix. except where indicated to the contrary, I/we understand that any statement made in this Supplementary Proposal Form will be treated by the insurer as a statement made by all persons to be insured; and
- x. I/we have read Vero's Privacy Statement which you have put before me/us in the Professional Indemnity Proposal Form, and consent to the use, disclosure and obtaining of personal information about the Insured for the purposes shown in the Privacy Statement; and
- xi. I/we acknowledge that this Supplementary Proposal forms part of the Professional Indemnity Proposal Form signed and dated on the date disclosed in question 2.

Signed

Name of Partner(s) or Director(s)

On behalf of*

Date