

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.
4. Please submit answers in an attached spreadsheet should the spaces provided be insufficient.

1. Name of all entities to be insured

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

3. Number of staff

a) Academic (total)

Full time equivalent

b) Non academic (total)

Full time equivalent

4. Number of students

a) Total student enrolments

b) Student load

Equivalent full time student load

5. Does the Insured operate a teaching hospital? Yes No

If Yes, please state the number of full time equivalent teaching staff and students for each discipline taught.

Discipline	Number of FTE teaching staff	Number of students
<input style="width: 520px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>
<input style="width: 520px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>	<input style="width: 150px; height: 25px;" type="text"/>

6. Does the Insured have students in clinical placements where they may provide health care? Yes No

If Yes, please state:
 (Please identify separately students involved with Obstetrics and/or Midwifery):

**For undergraduate students
 (please separate by Year of study)**

School	Discipline	FTE students	Total hours per annum for all FTE students
<input style="width: 290px; height: 25px;" type="text"/>	<input style="width: 320px; height: 25px;" type="text"/>	<input style="width: 140px; height: 25px;" type="text"/>	<input style="width: 190px; height: 25px;" type="text"/>
<input style="width: 290px; height: 25px;" type="text"/>	<input style="width: 320px; height: 25px;" type="text"/>	<input style="width: 140px; height: 25px;" type="text"/>	<input style="width: 190px; height: 25px;" type="text"/>
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6. continued...

School	Discipline	FTE students	Total hours per annum for all FTE students

For postgraduate students
(please separate by Year of study)

School	Discipline	FTE students	Total hours per annum for all FTE students

7. Does the Insured provide veterinary services? Yes No

If Yes, please give details.

8. Does the Insured provide on-site healthcare services for which cover is sought under this Policy (for example, university health services, sports rehabilitation, day surgery, counselling etc)? Yes No

If Yes,

a) For each please state:

Facility Name	Type of healthcare service	No. of healthcare professionals	Revenue last 12 months

b) Does the Insured require the healthcare professionals in each of these facilities to carry their own medical malpractice insurance? Yes No

c) Does the Insured employ/provide any healthcare professionals that provide medical services at facilities not operated by the Insured? Yes No

If yes, please state:

Discipline	Number of FTE healthcare professionals
<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. Does the Insured conduct clinical trials? Yes No

If Yes, please complete the Clinical Trials Supplementary Proposal available from <http://www.veroprofin.com.au/dirp/profin/profin.nsf/Content/SupplementaryProposals>

10. Does the Insured provide services to commerce or industry (paid or not)? Yes No

If Yes, please attach details of those services including the fees received for them.

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* * Insert Name of Firm

Date / /