

# **FIJI DENTAL ASSOCIATION**

## ***In-house Indemnity Cover – For Individual Dental Practitioners***



### **Your Duty of Disclosure** **Important Notices to the Applicant**

Before you enter into a contract of indemnity cover with FDA Inhouse Scheme , the insurer, you have a duty under the law to disclose to Trust Committee every matter within your knowledge that is material to Trust Committee decision whether to accept the risk of the cover and, if so, on what terms.

- You have the same duty to disclose those matters to Trust Committee before you renew, extend, vary or reinstate a contract of cover.
- It is important that all information contained in this application is understood by you and is correct, as you will be bound by your answers and by the information provided by you in this application.
- You should obtain advice before you sign this application if you do not properly understand any part of it.
- Your duty of disclosure continues after the application has been completed up until the contract of insurance is entered into.

### **Non-Disclosure**

- If you fail to comply with your duty of disclosure, Trust Committee may have the option of avoiding the contract of insurance from its beginning.
- If your non-disclosure is fraudulent, Trust Committee may also have the right to keep the premium that you have paid.

### **Change of Risk or Circumstances**

You should advise Trust Committee as soon as practicable of any change to your normal business as disclosed in this application, such as changes in business activities, location, acquisitions and new overseas activities.

### **Subrogation**

Where you have agreed with another person or company (who would otherwise be liable to compensate you for any loss or damage which is covered by the contract of insurance) that you will not seek to recover such loss or damage from that person, Trust Committee will not cover you, to the extent permitted by law, for such loss or damage.

### **Practical Considerations**

- Inform FDA promptly about any clinical negligence claims or potential claims against you.
- Act honestly with FDA and provide requested information.
- Don't admit or settle any claim without FDA's written consent.

### **General Exclusions**

The scheme won't cover you for:

- Claims covered by other insurance or indemnity.
- Claims related to services provided by non-FDA members.
- Claims not related to FDA-approved health and social care services.
- Claims related to services provided outside your FDA membership period.
- Any personal or trading debt, fines, penalties, or indirect losses.
- Claims related to property ownership, product manufacturing, or defamation.
- Claims related to aesthetic dental procedures.
- Claims arising from your insolvency, criminal activity, sexual misconduct, or intentional harm.
- Claims causing only financial loss.
- Self-employed members employing non-FDA health care workers.
- Members working abroad or facing legal proceedings in another country.
- Claims arising from HIV or Hepatitis Non-A infection.
- Members employed by general practitioners are not covered for work under their employment contract.
- FDA may withhold cover based on your claim's history.

### **Special Conditions**

- Voluntary work, including 'good Samaritan' acts, are not covered.
- First aid providers are not covered.
- Self-employed members or business owners are covered, subject to conditions.
- Business owners must understand the scheme exclusions.
- FDA cover is personal. Non-FDA members or those not benefiting from the scheme due to their employment status are not covered. You need separate insurance for your business.

# Instructions to the Applicant

- This form is intended for individual dental practitioners.
- You must answer all the questions in this form. If a question is not applicable, state “N/A”. If more space is required to answer a question, continue on your letterhead.
- Please note Period of cover will be effective from date of application to 31<sup>st</sup> December of the year

Application For Cover		
Period of Cover	From	To

Applicant Details Name: \_\_\_\_\_

Date of Birth: DD / MM / YYYY Gender: ☐Male ☐Female

1.1 Primary practice address: \_\_\_\_\_  
\_\_\_\_\_

1.2 Are you duly licensed to practice at the address(es) specified?  
☐Yes ☐No

1.3 Contact phone number: \_\_\_\_\_

1.4 Email address: \_\_\_\_\_

1.5 Please indicate your qualification(s):

Institution	Degree or Qualification	Year Obtained


1.6 Please provide the details of your registration below:

a) Licensing / Registration Body:

\_\_\_\_\_

b) Registration Number:

\_\_\_\_\_ c)

Registration Date:

\_\_\_\_\_

d) Registration Type:

\_\_\_\_\_

e) Date of first Registration:

\_\_\_\_\_

1.7 Other Registration Details (where applicable):

\_\_\_\_\_  
\_\_\_\_\_

1.8 Please list any medical societies & associations you are a member of:

\_\_\_\_\_  
\_\_\_\_\_

1.9 Have you ever had any of the above declared in questions 1.6, 1.7 and 1.8 refused, suspended, withdrawn or had conditions imposed at any time?

☐ Yes ☐ No

If **Yes**, please provide details

\_\_\_\_\_

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## Details of Healthcare Services

2 Do you provide healthcare services in your host country only?

☐ Yes ☐ No If **No**, please provide the breakdown of overseas services below:

Year	Country	Location/Practice Address
Current year		
Past year		

## Risk Management

3.1 Do you maintain accurate and descriptive records of all medical services rendered, and equipment used in procedures? ☐ Yes ☐ No

3.2 Is informed consent obtained from each patient and documented in their medical record?

☐ Yes ☐ No

If **No**, how often is informed consent obtained?

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3.3 Do you have facilities for sterilisation of instruments in accordance with relevant guidelines/standards applying to your industry ?

☐ Yes ☐ No?

3.4 Do you have a written procedure for the reporting of incidents and adverse events?

☐ Yes ☐ No

## Insurance History

4.1 Do you currently hold medical malpractice insurance?

☐ Yes ☐ No

If **Yes**, please provide details below:

Period of Insurance	Insurer	Policy Limit	Excess	Retroactive Date
		FJD	FJD	FJD
		FJD	FJD	FJD

4.2 Have you ever had any application for medical malpractice insurance refused, or had any medical malpractice insurance rescinded or cancelled? If **Yes**, please provide details on a separate sheet, noting the Section number."

☐ Yes ☐ No

### Claims Experience

- 5.1 Have any claims ever been made, or lawsuits been brought against you? ☐ Yes ☐ No
- 5.2 Are you aware of any errors, omissions, offences, circumstances or allegations which might result in a claim being made against you? ☐ Yes ☐ No
- 5.3 Have you ever been the subject of disciplinary action or investigation by any authority or regulator or professional body? ☐ Yes ☐ No
- 5.4 Have you ever been the subject of a criminal investigation or had criminal charges brought against you? ☐ Yes ☐ No
- For the purposes of this question, please disregard traffic or minor motor vehicle licensing offences.

If you had answered **Yes** to any of the questions in this section, please **provide full details overleaf** of the **status** of each claim, lawsuit, allegation or matter, including:

- the date of the claim, suit or allegation
- the date you notified your previous insurers
- the name of the claimant and the services rendered
- the allegations made against you
- the amount claimed by the claimant
- whether the status is outstanding or finalised
- the amounts paid for claims and defence costs to date

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**Declaration & Signature**

- I have read and understood the Important Notices contained in this application.
- I agree that this proposal, together with any other information or documents supplied, will form the basis of any contract of insurance.
- I acknowledge that if this application is accepted, the contract of insurance will be subject to the terms and conditions as set out in the policy wording as issued or as otherwise specifically varied in writing by Trust Committee.
- I declare, after inquiry, that the statements, particulars and information contained in this application and in any documents accompanying this application are true and correct in every detail and that no other material facts have been misstated, suppressed or omitted.
- I undertake to inform Trust Committee of any material alteration to those facts before completion of the contract of insurance.

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Signed by : .....

Title : .....

Date : .....

This form must be reviewed, signed, and dated by the duly authorised Dental Practitioner who is the Applicant, being the Principal, Partner, or Director.

**Personal Information Collection Statement**

The Trust Committee is committed to protecting your personal data. Trust Committee collects, uses, discloses and retains your personal and our own policies and procedures .The Trust Committee collects your personal data (which may include health information) when you apply for, change or renew an cover with us, or when we process a claim. We collect your personal data to assess your application for cover, to provide you with competitive insurance products with other external insurance providers and services and administer them, and to handle any claim that may be made under a policy. If you do not provide us with your personal data, then we may not be able to provide you with insurance products or services or respond to a claim.

We may disclose the personal data we collect to third parties for and in connection with such purposes, including contractors and contracted service providers engaged by us to deliver our services or carry out certain business activities on our behalf (such as actuaries, loss adjusters, claims investigators, claims

handlers, third party administrators, call centres and professional advisors, including doctors and other medical service providers), other companies within the Trust Committee Group, other insurers, our reinsurers, and government agencies (where we are required to by law). These third parties may be located outside of Fiji.

You consent to us using and disclosing your personal data as set out above. This consent remains valid until you alter or revoke it by providing written notice to Trust Committee’s. If you withdraw your consent, then we may not be able to provide you with insurance products or services or respond to a claim. From time to time, we may use your personal data to send you offers or information regarding our products and services that may be of interest to you. If you do not wish to receive such information, please provide written notice to Trust Committee’s secretary.



