



Medical Liability Insurance For NZACA Member Nurses

Please return this form with payment to
New Zealand Aged Care Association PO Box 12481
Wellington 6144 or julie@nzaca.org.nz

APPLICANT DETAILS – (Must be working for a member of the Association to qualify for this insurance)

Name			
Name of the Home/Care facility where you work			
Your Postal Address		Post Code	
Email		Phone	
Qualifications		Year Obtained	
Classification	Registered Nurse <input type="checkbox"/>	Practice Nurse <input type="checkbox"/>	Nurse Practitioner <input type="checkbox"/> Enrolled Nurse <input type="checkbox"/>

Where is your Main Place of Business

Retirement Village	<input type="checkbox"/>	Dementia Care Facility	<input type="checkbox"/>
Residential Care Home	<input type="checkbox"/>	Within Psychogeriatric Facility	<input type="checkbox"/>
Residential Care Hospital	<input type="checkbox"/>	Other (Please describe)	<input type="checkbox"/>

DECLARATION

Have you been the subject of any claim or complaint in connection with your professional services in the past five years? (examples: a complaint; allegations of medical malpractice, negligence, duty of care standard; disciplinary proceedings or an investigation or inquiry)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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If Yes please provide details

I hereby declare that the above statements and particulars are in all respects complete and true, and that I have not suppressed or misstated any material facts and I agree that this application form shall be the basis of the contract with underwriters and deemed part of the insurance coverage issued to me

I understand that underwriters are collecting this information to evaluate and consider my application. And that I have rights to access and correct this information.

Printed Name		Date	
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PAYMENT *Your application for cover may be subject to insurer review if you have been the subject of past claims notifications or your main place of business is 'other'. Insurance coverage is subject to payment of the required premium. The insurance has an anniversary renewal date of 1 August. If you are joining outside of this date, please contact your Association for the premium amount to pay as discounted premiums apply for a period less than twelve months.*

ANNUAL PREMIUM	\$156 inc. GST		
Method of Payment	Cheque (attached) <input type="checkbox"/>	Direct Deposit <input type="checkbox"/>	Account name - New Zealand Aged Care Association Incorporated Account number – 12-3244-0043262-00 Please quote for reference your surname, initials and 'Nurses Liability Insurance'
Run-Off Insurance	If you have ceased to practise do you require run-off insurance to cover against the risk of a claim or complaint being taken against you for past activities? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please provide reason for your ceasing to practise and complete this application form. The premium for 3 years run-off insurance is based on the premium shown on the application form. The run-off insurance is subject to completion of a No Claims Declaration form each year until the 3 years of run-off expires.		