Aged Care Association NEW ZEALAND

# Medical Liability Insurance For ACA Member Nurses

**Please return this form with proof of payment to**
Aged Care Association office@nzaca.org.nz

## APPLICANT DETAILS
(You must be working in aged care for a member of ACA to qualify for this insurance)

| | | | |
|---|---|---|---|
| Your Name | | | |
| Name of the Home/Care facility where you work | | | |
| Your Postal Address | | Post Code | |
| Email | | Phone | |
| Qualifications | | Year Obtained | |
| Classification | Registered Nurse ☐ | Practice Nurse ☐ | Nurse Practitioner ☐ | Enrolled Nurse ☐ |

Where is your Main Place of Business

| | | | | |
|---|---|---|---|---|
| Retirement Village ☐ | Dementia Care Facility ☐ | Residential Care Home ☐ | Residential Care Hospital ☐ | Within Psychogeriatric Facility ☐ |
| Other (Please describe) ☐ | | | | |

## 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** ☐ **NO** ☐

***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 right to access and correct this information.

| | | | |
|---|---|---|---|
| Printed Name | | Date | |

## 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 a common renewal date of 1 August. Short term premium apply as follows: $143.75 inc if you join from 1/12/2023 and $86.25inc if you join from 1/4/2024*

| | |
|---|---|
| TOTAL PREMIUM | $213.90 inc. GST |
| Method of Payment | Account name - New Zealand Aged Care Association Incorporated<br>Account number – 12-3244-0043262-00<br>Please quote for reference your surname, initials and 'Nurses Liability Insurance'<br>Please also ensure proof of payment is included in your submission of your insurance renewal. We cannot process your application if you do not enclose this. |
| Run-Off Insurance (This section is only applicable if you have ceased practice) | 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 ☐ No ☐<br>If so, please provide reason for your ceasing to practise and complete this application form.<br>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. |