



**APPLICANT DETAILS**

Please Note: You must be a current member of ACANZ AND be working in aged care to qualify for this insurance.

Your Name:

Name of the 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                      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? (e.g., a complaint, an allegation of medical malpractice, negligence or duty of care standard, disciplinary proceedings, or an investigation or inquiry)                      Yes                      No

If you answered 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. 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

**PREMIUM**

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 upon receipt of Aon tax invoice. The insurance has a common renewal date of 1 August. Short-term premiums apply as follows: \$98.90 (GST incl.) if you join from 1/4/2024

**TOTAL ANNUAL PREMIUM**                      \$230.00 inc. GST

**Payment Preference**

(due upon receipt of the Aon Tax Invoice)

I will pay the invoice (please invoice me)

My employer will pay the invoice (please invoice my employer)

Name of Employer:

**RUN-OFF INSURANCE**

Please Note: This section is only applicable if you have ceased practise.

The premium for three 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 three years of run-off expires.

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

If so, please provide the reason you ceased to practise:

Please Note: This proposal is a writeable PDF and MUST NOT be handwritten.