

# Avant Practitioner Indemnity Insurance Policy Application form



## Practitioner Indemnity Policy with Avant Insurance Limited ACN 003 707 471 AFSL 238765

Effective: April 2026

This is an application form for Membership and a Practitioner Indemnity Insurance Policy. It is a legal document which will form (a) the basis of the contract of insurance between the insured (you) and Avant Insurance Limited (Avant Insurance); and (b) the basis of your contract of Membership with Avant Mutual Group Limited ABN 58 123 154 898 (Avant). When reading this document a reference to 'we', 'our' and 'us' will mean Avant Insurance. 'You' and 'your' will mean the insured.

**Your duty of disclosure:** Before you enter into an insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms. You have this duty until we agree to insure you.

You have the same duty before you renew, extend, vary or reinstate an insurance contract. You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay you if you make a claim, or both. If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed. Please read the Practitioner Indemnity Insurance Policy, complete this form, and accept the declarations. You can find the Practitioner Indemnity Insurance Policy wording online at [avant.org.au](http://avant.org.au). Please contact us on **1800 128 268** with any questions.

Avant Insurance Limited is part of the Avant Mutual Group which includes Avant Mutual Group Limited and its related entities (Avant). Avant collects, uses and discloses your personal information to communicate with you, conduct our business (including marketing, research and providing Avant products and services) and comply with the law. This may include disclosing information to overseas entities which are not accountable under Australian privacy laws and you may not be able to seek redress for a breach of your privacy which occurs outside of Australia. If you don't provide your information we may not be able to assist you or provide our products or services. For more information, please read our Privacy Policy at [Privacy policy - Avant](#) or contact our Privacy Officer at [privacy@avant.org.au](mailto:privacy@avant.org.au). By providing your information you confirm that you understand, acknowledge and agree to your information being collected, used and disclosed as outlined above and in accordance with the Privacy Policy, including for receiving marketing from Avant and overseas disclosures. You can contact us at any time if you have any questions or wish to change your consent.

1. Your details					
Title		First name		Last name	
Date of birth		Sex at birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred pronouns	
Mobile		Work telephone			
Email					
Alternate email					
Residential address					
Primary practice address					
Preferred mailing address	<input type="checkbox"/> Residential	<input type="checkbox"/> Practice			
2. Qualification and registration information Please list your medical qualifications					
a) Medical qualifications					
Qualification		Additional qualification			
University/institution		University/institution			
Year awarded		Year awarded			
Country		Country			
b) Do you require a temporary visa to work in Australia? If <b>YES</b> please attach a copy.				<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Please provide your Ahpra registration details			Registration number		
d) Has your registration to practice as a healthcare practitioner ever been refused, revoked, suspended or had conditions applied to it or has there ever been a matter brought before a registration board? If <b>YES</b> , please provide details in the 'additional information' section or on a separate page.				<input type="checkbox"/> Yes	<input type="checkbox"/> No

### 3. Medical practice information

a) What is your category of practice? Please refer to the Category of Practice Guide to identify the category that covers the healthcare you provide.

b) Do you hold a public appointment?  Yes  No

c) Do you require cover for the treatment of public patients where you are **NOT** entitled to indemnity from any other source (including but not limited to a state government, hospital or area health service, another person or your employer)?  Yes  No

If **YES**, please provide details about the workplace where you will be treating public patients in the 'additional information' section or on a separate page and provide your estimated annualised gross income for public practice below.

d) Please provide your estimated annualised gross billings\* for the next 12 months:

\*Please read the definition of gross billings in the Category of Practice Guide. You must provide an accurate estimate of your annual gross billings otherwise you may not be covered in the event of a claim against you.

Private practice	\$
Public practice income (only complete if YES above)	\$

e) Do you perform any cosmetic procedures? I.e. procedures for which there is no Medicare item number assigned, or for which a Medicare item number is assigned but it not claimable?  Yes  No

If **YES**, please provide details in the 'additional information' section or on a separate page.

f) Do you provide any healthcare which would not normally fall within the scope of your speciality or field of practice?  Yes  No

If **YES**, please provide details in the 'additional information' section or on a separate page.

g) In the last 5 years have you:  
i. changed your category of practice  Yes  No  
ii. changed your billings by more than 50%  
iii. changed your location  
iv. practiced under a different name

If **YES**, please provide details, including year, speciality, annual billings and/or location in the 'additional information' section or on a separate page.

### 4. Past claims, incidents and registration If YES to any of the below, please provide details in the 'additional information' section or on a separate page.

a) Have you or a practice in which you work or worked:  
i. ever been subject to an investigation, complaint, inquiry (including Medicare inquiry), audit, coronial inquest or proceeding; or  
ii. ever been involved in any claims, demands, suits or other legal actions; or  
iii. ever been counselled, disciplined or had authorisations altered by an employer, a hospital, an area health authority, a medical college, a statutory body or a medical board in relation to your conduct as a healthcare professional.  Yes  No

b) Are you:  
i. aware of any act, error, omission or circumstance in respect of your conduct as a healthcare professional; or  
ii. aware of any matter or potential matter, including any potential defamation dispute, employer or employee dispute or audit by the Australian Tax Office that was or could have been notified under any insurance policy that was or is in force prior to the inception of this policy?  Yes  No

c) Have you:  
i. ever been diagnosed with or treated for cognitive impairment or any other health conditions that may affect your performance as a healthcare professional; or  
ii. ever been charged with, convicted or found guilty of a criminal offence in any country; or  
iii. ever made a self notification or been the subject of a voluntary notification to Ahpra?  Yes  No

## 5. Past insurance and medical indemnity details

a) Have you ever been indemnified by an Australian medical defence organisation or insurance company in the past?  Yes  No

If **YES**, please provide details:

Insurer				
Start date		End date		Retroactive date
Insurer				
Start date		End date		Retroactive date

b) Have you:  
 i. ever had an application or renewal for professional insurance refused; or  
 ii. had a loading, deductible or special condition placed on your insurance; or  
 iii. been offered or provided with a reduced level of cover; or  
 iv. had your application declined; or  
 v. had your policy cancelled?  Yes  No

If **YES**, please provide details in the 'additional information' section or on a separate page.

c) Have you ever worked in the public sector where you have **NOT** been entitled to indemnity from any other source (including but not limited to a state government, hospital or area health service, another person or your employer)?  Yes  No

If **YES**, please provide details about the workplace where you were treating public patients in the 'additional information' section or on a separate page and provide your estimated income for that period of public practice.

## 6. Policy details

a) If your application is approved, your cover will start from the date we approve your application unless you would like a future date. If so please specify.

When would you like this policy to end?  30 June  31 December

Retroactive cover is cover for your past practice. This protects you from claims that may arise from healthcare provided by you in the past. We will note your retroactive date as your first date of registration in Australia. Please contact us if you would like this updated.

Note: Your policy schedule may also list your retroactive date as 'unlimited' this will also provide cover back to the date of first registration.

b) Do you require additional retroactive cover because:  
 i. you were not covered by an insurance policy in the past; or  
 ii. you returned to private practice after a period of no private practice; or  
 iii. you previously changed insurer and did not take out run off cover?  Yes  No

For more information visit [avant.org.au/retroactive-cover](http://avant.org.au/retroactive-cover)

If **YES**, please provide details:

Date from		Date to	
Date from		Date to	

c) The Premium Support Scheme (PSS) is an Australian Government scheme that helps you with the costs of your medical indemnity insurance. If you are eligible, you may receive a significant reduction in your practitioner indemnity insurance premium charged by Avant.  Yes  No

Would you like to participate in the PSS?

If **YES**, we will send you Premium Support Scheme terms and conditions and Premium Support Scheme request form. Please refer to the terms and conditions for details of the eligibility criteria. You can access the booklet online at [avant.org.au](http://avant.org.au) or by requesting a copy from Member Services on 1800 128 268.

d) Do you wish to apply for personal expenses optional cover and interruption to earnings optional cover?  Yes  No  
 For more information about this option and what this covers you for, please refer to Part C of the Avant Practitioner Indemnity Insurance Policy.

## Electronic communications disclosure and consent

You will receive the product disclosure statement, renewal documentation, Financial Report and Annual Report electronically. If you wish to change this option please email us as [memberservices@avant.org.au](mailto:memberservices@avant.org.au) or contact **1800 128 268**.

I consent to Avant contacting me in accordance with Avant's Privacy Policy (including via email and SMS if you have provided your email address and mobile number). I understand that I may alter this consent at any time by contacting Avant.

You will receive the notice of Annual General Meeting and other member communications from Avant electronically. If you wish to change this option please email us as [memberservices@avant.org.au](mailto:memberservices@avant.org.au) or contact **1800 128 268**.

Please ensure that you maintain a current email address with us at all times so that we can ensure the successful delivery of communications to you. If you change address, change practice details or move overseas please let us know.

## 7. Application and declaration

I hereby apply for membership of Avant and for a Practitioner Indemnity Insurance Policy from Avant Insurance. I agree to be bound by the Constitution of Avant and the terms of any insurance issued to me by Avant insurance. I declare that by signing, typing my name, or entering an electronic signature in the space provided and returning this form that:

- |   |   |
|---|---|
| <p>a) the information I have given in this application form and in any accompanying documents is true and correct, and I understand that Avant Insurance will rely on this information in deciding whether to provide me with an insurance contract and on what terms and conditions, and that it will form the basis of my policy</p> <p>b) I acknowledge and accept the retroactive cover date as set out on my policy for all prior uncovered incidents and I agree to accept all future offers of retroactive cover as set out in the policy and this application form, unless I otherwise advise Avant Insurance in writing. If I decide not to accept any offer of retroactive cover or future offers of retroactive cover, I may be uninsured for incidents occurring prior to the commencement date of my policy</p> <p>c) if I have asked for public patient cover I understand that I need to determine if I am entitled to cover for civil liability for public patients from a hospital, area health service, a government scheme, or another person and that cover for civil liability will only be provided to me where I have no right to indemnity</p> <p>d) I understand my duty of disclosure exists until the contract of insurance is entered into and that I have a continuing obligation to inform Avant Insurance of any material alteration of the risk during the policy period – including any change in the nature or location of my practice or my billings (if any)</p> <p>e) I have read and understood the Product Disclosure Statement, Practitioner Indemnity Insurance Policy, Category of Practice Guide and Constitution of Avant and I acknowledge that cover is subject to the terms, conditions and exclusions of the Policy</p> | <p>f) I understand this application is subject to approval by Avant and Avant Insurance. I acknowledge that if a contract of insurance is issued it will be subject to the terms and conditions of the policy provided to me or as otherwise specifically varied by Avant Insurance and agreed to by me</p> <p>g) I authorise Avant Insurance to discuss and obtain information or documents in relation to insurance matters or claims history from another insurance company, MDO or an insurance reference bureau or similar organisation</p> <p>h) I authorise Avant Insurance to obtain information and documents in relation to my registration, conditions of my registration or any other matter from any Medical Board or other registration body</p> <p>i) I understand I may be required to participate in an audit to verify my category of practice and/or my gross private practice billings (if any) and that I must cooperate and facilitate such an audit. This may include the provision of a Statutory Declaration by me with regard to my gross billings for private practice.</p> <p>j) I confirm that I understand, acknowledge and agree to my information being collected, used and disclosed as outlined in the Privacy Notice above and in accordance with the Avant Privacy Policy, including for receiving marketing from Avant and overseas disclosures.</p> |
|---|---|

Print name  
(as it appears on your Ahpra registration)

Signature

Date

Please return this form by email to [applications@avant.org.au](mailto:applications@avant.org.au) or contact us on **1800 128 268**.

IMPORTANT: Professional indemnity insurance from Avant Mutual Group Ltd ABN 58 123 154 898 is issued by Avant Insurance Ltd, ACN 003 707 471, AFSL 238 765. The information provided is general advice only and does not take into account your objectives, financial situation and needs. Please read the PDS available at [avant.org.au/practitioner-indemnity-insurance](http://avant.org.au/practitioner-indemnity-insurance) or by contacting us on 1800 128 268 to see if the insurance is right for you. MIM-2051 04/06. Terms, limits, conditions, and exclusions apply.

8. Would you like more information on any of the following?

- Travel cover    Health insurance    Life insurance    Financial services    Legal services    Proactive risk support

9. Additional information

Section number	Additional details

# Notes

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