

# Avant Practitioner Indemnity Insurance

## Acceptance of Offer Form for International Medical Graduates



Membership with Avant Mutual Group Limited ABN 58 123 154 898.

Practitioner Indemnity Insurance with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765.

Version: July 2025.

This is an Acceptance of Offer Form for Membership and a Practitioner Indemnity Insurance Policy for practitioners that satisfy the selection criteria. This membership and policy applies only to members residing in Australia and for use in Australia. This 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 (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.

### This Acceptance of Offer Form only applies if you meet all the following selection criteria:

1. You must be an internationally qualified medical practitioner and have gotten your Ahpra registration number for the first time within the last 3 years.
2. You must hold professional registration from the Medical Board of Australia.
3. You must be employer indemnified and not performing healthcare in a private setting and generating billings.
4. You have answered "no" to all of the questions asked in the "Claims, Complaints, Incidents or Proceedings" section of this form. Where you have answered yes, we may require additional information prior to finalising your policy.

If you fall outside of the selection criteria this Acceptance of Offer Form does not apply to you and we will contact you for further information.

### Contact information Please write clearly in BLOCK letters

Title		First name		Last name	
Gender*	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth		Mobile	
*Supporting our gender diverse community. We are currently reviewing our gender and sex at birth options to ensure our products and services provide appropriate terminology and selections in line with the diversity of our community.					
Email					
Residential address in Australia					

### Qualifications and registration information Please list your medical qualifications

Qualification		Year awarded	
University / Institution		Country	
Qualification		Year awarded	
University / Institution		Country	
Do you require a temporary visa to work in Australia?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES please attach a copy if you have this
Please provide your Ahpra registration details			
Registration number		First year of registration	

### Medical practice information

What is your category of practice? Please refer to the Category of Practice Guide to identify the category that covers the healthcare you provide.	
Do you hold a public appointment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Claims, complaints, incidents or proceedings

If you answer YES to any of the following questions, we may contact you for additional information before accepting your application.

- a) Have you ever been the subject of, or involved in, a claim, complaint, investigation inquiry or proceeding, or has there been an incident (including an act or error) which may lead to a claim or complaint in connection with your training or from healthcare provided by you? ☐ Yes ☐ No
- b) Have you ever been refused registration, suspended or deregistered in any country, or have there been any conditions or limitations on your registration? ☐ Yes ☐ No
- c) Have you ever made a self-notification or been the subject of a voluntary notification to Ahpra? ☐ Yes ☐ No
- d) Have you ever been counselled, disciplined or had authorisations altered by an employer, medical college, statutory or medical board? ☐ Yes ☐ No
- e) Have you ever been charged with, convicted or found guilty of a criminal offence? ☐ Yes ☐ No

## Membership and insurance offer

Policy period	Policy details	Amount
<p>From the date I provide in this completed Acceptance of Offer form to Avant Insurance to the following date – within the next 12 months (please select one):</p> <p><input type="checkbox"/> 30 June <input type="checkbox"/> 31 December</p> <p>The maximum policy period can not be greater than 12 months.</p>	<p><b>Avant Practitioner Indemnity Insurance Policy</b></p> <p><b>Retroactive cover</b> from the retroactive date you nominate below</p>	<p>The cost of this policy is <b>\$850</b> (inc. GST) per year for a total of 3 years. This includes indemnity and membership.</p>

## Retroactive indemnity

Retroactive cover (also known as tail cover) is protection for the healthcare you provided after your retroactive cover date and before the start date of your current medical indemnity insurance policy. This is subject to other exclusions in the policy, particularly the exclusion for 'known circumstances' which should have been notified to another insurer. Please nominate a retroactive cover date that covers all healthcare you have provided within Australia. This is usually the date you first registered with Ahpra. For more information on retroactive cover visit [avant.org.au/retroactive-cover](http://avant.org.au/retroactive-cover).

Nominated retroactive date. (Note that it is a requirement of eligibility that you have no gaps in cover). (DD/MM/YYYY)

## Electronic communications disclosure and consent

You will receive the product disclosure statement, renewal documentation, Financial Report and Annual Report electronically. If you wish to receive these by post, please email us at [memberservices@avant.org.au](mailto:memberservices@avant.org.au).

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 to the email address you have nominated. If you wish to receive these by post, please contact us at [memberservices@avant.org.au](mailto:memberservices@avant.org.au).

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.

## Payment details (either credit card or direct debit)

<b>Credit card</b>	<input type="checkbox"/> Mastercard <input type="checkbox"/> Visa		
Name on card		Total amount	<b>\$850 annually</b> (inc. GST)
Card number		Expiration date	
Signature		Date	

OR

## Direct debit request authority form

I/We authorise Avant Insurance Limited (under User ID 010731) to arrange for payments, including payments for automatic renewal of my membership, to be debited from my/our nominated account through the Bulk Electronic Clearing System (BECS) in accordance with terms described in the Avant Insurance Direct Debit Request Service Agreement.

Financial Institution		BSB number	
Account name		Account number	
Signature 1		Date	
Signature 2		Date	

If debiting from a joint bank account, both signatures are required.

This is your Direct Debit Service Agreement with Avant Insurance (under User ID 407295 or User ID 010731, as identified in the DDR). It explains what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit provider.

Please keep this agreement for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR authorisation.

### Definitions

**Account** means the account held at your financial institution from which we are authorised to arrange for funds to be debited.

**Agreement** means this Direct Debit Request Service Agreement between you and us.

**Banking day** means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.

**Debit day** means the day that payment by you to us is due.

**Debit payment** means a particular transaction where a debit is made.

**Direct Debit Request** means the written, verbal or online request between us and you to debit funds from your account.

**Us or we** means Avant Insurance, (under User ID 407295 or User ID 010731, as identified in the DDR) you have authorised by requesting a Direct Debit Request.

**You** means the customer who has authorised the Direct Debit Request.

**Your financial institution** means the financial institution at which you hold the account is maintained you have authorised us to debit.

### 1. Debiting your account

1.1 By submitting a Direct Debit Request, you have authorised us to arrange for funds to be debited from your account. The Direct Debit Request and this agreement set out the terms of the arrangement between us and you.

1.2 We will only arrange for funds to be debited from your account as authorised in the Direct Debit Request; or

We will only arrange for funds to be debited from your account if we have sent to the email/address nominated by you in the Direct Debit Request, a billing advice which specifies the amount payable by you to us and when it is due.

1.3 If the debit day falls on a day that is not a banking day, we may direct your financial institution to debit your account on the following banking day. If you are unsure about which day your account has or will be debited you should ask your financial institution.

### 2. Amendments by us

2.1 We may vary any details of this agreement or a Direct Debit Request at any time by giving you at least 14 days written notice sent to the preferred email/address you have given us in the Direct Debit Request.

### 3. How to cancel or change direct debits

You can:

- a) cancel or suspend the Direct Debit Request; or
- b) change, stop or defer an individual debit payment at any time by giving at least 14 days notice.

To do so, contact us at **1800 128 268** during business hours; or

You can also contact your own financial institution, which must act promptly on your instructions.

### 4. Your obligations

4.1 It is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the Direct Debit Request.

4.2 If there are insufficient clear funds in your account to meet a debit payment:

- a) you may be charged a fee and/or interest by your financial institution;
- b) we may charge you reasonable costs incurred by us on account of there being insufficient funds; and
- c) you must arrange for the debit payment to be made by another method or arrange for sufficient clear funds to be in your account by an agreed time so that we can process the debit payment.

4.3 You should check your account statement to verify that the amounts debited from your account are correct.

### 5. Dispute

5.1 If you believe that there has been an error in debiting your account, you should notify us directly on **1800 128 268** or email **memberservices@avant.org.au**

Alternatively you can contact your financial institution for assistance.

5.2 If we conclude as a result of our investigations that your account has been incorrectly debited we will respond to your query by arranging within a reasonable period for your financial institution to adjust your account (including interest and charges) accordingly. We will also notify you in writing of the amount by which your account has been adjusted.

5.3 If we conclude as a result of our investigations that your account has not been incorrectly debited we will respond to your query by providing you with reasons and any evidence for this finding in writing.

### 6. Accounts

You should check:

- a) with your financial institution whether direct debiting is available from your account as this is not available on all accounts offered by financial institutions.
- b) your account details which you have provided to us are correct by checking them against a recent account statement; and
- c) with your financial institution before completing the Direct Debit Request if you have any queries about how to complete the Direct Debit Request.

### 7. Confidentiality

7.1 We will keep any information (including your account details) in your Direct Debit Request confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

7.2 We will only disclose information that we have about you:

- a) to the extent specifically required by law; or
- b) for the purposes of this agreement (including disclosing information in connection with any query or claim).

### 8. Contacting each other

8.1 If you wish to notify us in writing about anything relating to this agreement, you should write to:

**Avant Insurance Limited**  
**PO BOX 746**  
**Queen Victoria Building NSW 1230**

8.2 We will notify you by sending a notice to the preferred address or email you have given us in the Direct Debit Request.

Any notice will be deemed to have been received on the second banking day after sending.

Before signing the declarations, please review the information you have provided and ensure that you have answered all sections accurately and to the best of your knowledge and belief.

## Application and declaration

I hereby apply for membership with 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 policy issued to me by Avant Insurance.

I declare that:

- a) the information I have given in this Acceptance of Offer 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
- b) the retroactive date I have selected is adequate to cover me 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.
- c) 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).
- d) 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.
- e) 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.
- f) 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.
- g) 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.
- h) I accept that my membership will start from the date that I provide this completed Acceptance of Offer form to Avant and the cost of my membership will be pro-rated if the period is less than 12 months.
- i) I accept that my membership and contract of insurance will start from the date that I provide this completed Acceptance of Offer form to Avant only if the selection criteria referred to above is satisfied by me. I acknowledge that the contract of insurance 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.

Print name			
Signature		Date	

Please return this form to **Avant Insurance Limited PO BOX 746 Queen Victoria Building NSW 1230**, or email **[applications@avant.org.au](mailto:applications@avant.org.au)** or contact us on **1800 128 268**.

**Privacy Notice and Consent:** 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. 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 [avant.org.au/privacy-policy](http://avant.org.au/privacy-policy) 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.

**IMPORTANT:** Professional Indemnity insurance products are issued by Avant Insurance Limited (ACN 003 707 471, AFSL 238 765) ("AIL"), a public company incorporated in Australia. AIL is an Australian general insurer that is regulated by the Australian Prudential Regulation Authority, and subject to the Australian Financial Complaints Authority dispute resolution scheme. This publication is intended for Australian residents only and does not constitute financial or personal advice. The information provided by AIL is general advice only and has been prepared without taking into account your objectives, financial situation and needs. You should consider these, and the relevant Product Disclosure Statement or policy wording (available at [www.avant.org.au](http://www.avant.org.au) or by contacting Avant Insurance on 1800 128 268), having regard to the appropriateness of the advice before deciding to purchase or continue to hold these products. 05/25 (MIM-1304)

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