

**Membership with Avant Mutual Group Limited ABN 58 123 154 898.**  
**Practitioner Indemnity Insurance 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 (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 Please write clearly in **BLOCK** letters

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

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

### 3. Medical practice information

Which of the following best describes your current career stage?

#### Senior Resident Medical Officer PGY3-5 (SRMO)

Postgraduate year 3

Postgraduate year 4

Postgraduate year 5

Hospital Registrar from PGY11 onwards – membership fees in this circumstance will be confirmed during application.

#### Other career stages

You are a General Practice Registrar currently enrolled in a training programme accredited by either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). This includes doctors working towards FRACGP or FACRRM through the following pathways: Remote Vocational Training Scheme (RVTS), Rural Generalist Training Scheme (RGTS), ACRRM Independent Pathway

If you are not currently enrolled in an approved training programme, please complete a practitioner application, form instead. This is available at [avant.org.au/products/medical-indemnity/practitioner-indemnity-insurance-policy](http://avant.org.au/products/medical-indemnity/practitioner-indemnity-insurance-policy)

Hospital or unaccredited registrar (under PGY11) commencing a training program within two years

Postgraduate year 11 onwards

Specialist in training enrolled in a specialist training program

Speciality

In which month and year do you anticipate you will complete your specialist training program? (MM/YYYY)

### 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, investigated, disciplined or had authorisations altered by an employer, a hospital, an area health authority, a medical college, a statutory body or had a dispute with a medical board in relation to your conduct as a healthcare professional; or
- iv. 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?

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 ever:

- i. been diagnosed with or treated for cognitive impairment or any other health conditions that may affect your performance as a healthcare professional; or
- ii. been charged with, convicted or found guilty of a criminal offence in any country; or
- iii. 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? If YES, please provide details:  Yes  No

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. (DD/MM/YYYY)

b) 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.

c) 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

d) Do you wish to apply for personal expenses optional cover and interruption to earnings optional cover?

For more information about this option and what this covers you for, please refer to Part C of the Avant Practitioner Indemnity Insurance Policy.

Yes  No

## 7. 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.

**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.**

## 8. 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) 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</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, medical defense organisation 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. Any claim or circumstances which might give rise to a claim or request for indemnity, which:</p> <ul style="list-style-type: none"> <li>i) you knew about or a person in your position ought reasonably to have known about and thought might result in a claim or allegation being made against you;</li> <li>ii) you notified us, or failed to notify us, of before the policy period commenced; or</li> <li>iii) you notified, or ought reasonably to have notified to another insurer</li> </ul> <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> <p>k) I understand that this policy, should it be accepted, will not respond to any matters that are known to me, or a reasonable person ought to have known, prior to the inception of the policy or pending claim or circumstances.</p> |
|--|---|

Print name as it appears  
on your Ahpra registration

Signature

Date

Please return this form to Avant Insurance Limited by emailing [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/doctor-in-training-indemnity-insurance-policy](http://avant.org.au/doctor-in-training-indemnity-insurance-policy) or by contacting us on 1800 128 268 to see if the insurance is right for you. Terms, limits, conditions, and exclusions apply. MIM-2052 (MIM-2045) 04/26



# Notes

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