

# Practice Medical Indemnity Policy Application form



**Practice Medical Indemnity Policy with Avant Insurance Limited ABN 82 003 707 471 AFSL 238765**  
Effective March 2026

This is an application form for a Practice Medical Indemnity Policy. This is a legal document, which will form the basis of the contract of insurance between the legal entity applying for insurance cover ('you' or 'your') and Avant Insurance Limited ('we', 'our', 'us' or 'Avant Insurance').

## 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 Practice Medical Indemnity Policy wording, complete this form, and accept the declarations. You can find the Practice Medical Indemnity 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.

Practice details			
1. Name and ABN/ACN of principal business to be insured (e.g. parent company or trustee)			
Incorporated name of principal business to be insured			
Trading name			
ABN			
ACN (if applicable)			
Practice website			
<b>Important notice</b>			
The definition of insured automatically includes companies that are subsidiaries of the principal business. If you are seeking cover for multiple businesses, please include each business as a principal insured.			
2. Is the business	<input type="checkbox"/> Sole trader	<input type="checkbox"/> Listed public company	<input type="checkbox"/> Not for profit (exempt from stamp duty, certificate required)
	<input type="checkbox"/> Partnership	<input type="checkbox"/> Unlisted public company	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Trust structure entity	<input type="checkbox"/> Subsidiary of a company	
	<input type="checkbox"/> Private company	<input type="checkbox"/> Not for profit (non-exempt from stamp duty)	
3. Date the principal business was established			
4. Address and contact details of principal practicing office			
Address			Phone number
			Email
			Alternative email
5. Do you operate from more than one location?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please provide details			

## Agent and authorised representative

6 a) Please complete details for the primary authorised contact person e.g. practice manager or director. This person will have authority to liaise with Avant Insurance and can make changes to the policy.

Name		Title		Position	
Email		Mobile			
DOB		Password			

b) Please specify any other practice staff that you would like to have access for enquiry only.

Name		Title		Position	
Email		Mobile			
DOB		Password			

Name		Title		Position	
Email		Mobile			
DOB		Password			

## Healthcare services

7. Your policy covers you for the healthcare services that you disclose to Avant. Please provide a full description of the healthcare services that are to be covered and type of medical practice. Please ensure that you disclose all services provided, or that you are intending to provide during the next 12 months, including by companies that are subsidiaries of the principal business, otherwise you may not be fully covered..

Type of medical practice					
Services provided					

8. Financial activity of the practice. The gross billings and annual revenue of your practice provides us with an indication of the volume of healthcare services provided by your practice and the exposure your practice has to claims. They must be as accurate as possible otherwise you may not be fully covered.

All healthcare services gross billings		Annual revenue	
Next financial year (estimate)	\$	Next financial year (estimate)	\$
Current financial year	\$	Current financial year	\$
Actual last financial year	\$	Actual last financial year	\$

9. Please advise percentage of annual revenue by state or territory below.

Note if you require cover for overseas, please attach a separate sheet providing details of the services.

NSW		VIC		QLD		ACT		WA		SA		NT		TAS	
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10. Does the practice undertake any of the following services?

Day surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, number of outpatients		Number of overnight beds	
Obstetrics services (shared antenatal services excluded)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, percentage of annual turnover from this activity			
Cosmetic services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, percentage of annual turnover from this activity			
Telehealth services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, percentage of annual turnover from this activity			
Anaesthetic services	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Clinical trials	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Termination of pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
If YES, please provide details.						

11. Is the practice participating in any joint ventures?  Yes  No

If **YES**, please attach details separately.

12. Has the practice conducted other healthcare services in the past, which have not been described above for which you require cover for?  Yes  No

If **YES**, please provide details.

13. Does the practice perform activities or provide services outside of Australia which you require cover for?  Yes  No

If **YES**, please provide details.

14. Does the practice provide any administration or computer/IT services to other healthcare providers?  Yes  No

If **YES**, please provide details.

15. Is the practice required to be accredited or licenced in order to provide the healthcare services that cover is being requested for?  Yes  No

16. Has the practice been formally accredited in the past 12 months (AGPAL, GPA, Medicare Local, ISO, APA etc.)?  
If **NO**, please attach more information separately as to what formal risk management framework and/or accreditation regime you operate under.  Yes  No

**Details of persons engaged in the business**

17. Does the practice employ a full time practice manager?  Yes  No

If **YES**, please provide name of practice manager and any relevant qualifications.

18. Please provide details of allied healthcare professionals and other healthcare professionals (other than medical practitioners, including technicians) engaged in the business. Attach a separate page if more information needs to be provided.

Name	Category of practice	Status (director, employee, contractor, room rental)	Insurer

**Details of persons engaged in the business**

19. Does the practice check at commencement and annually that each medical practitioner or contractor providing healthcare services

- Holds appropriate medical/professional indemnity insurance and
- Is registered to provide the services that they provide and
- Is appropriately qualified for the duties they undertake?

Yes     No

If **NO**, please provide details

20. Do any practice staff provide healthcare services to patients without supervision of a medical practitioner?  Yes     No

If **YES**, please provide details

21. Please provide details of medical practitioners engaged in the business (note that medical practitioners must hold their own professional indemnity insurance cover). Attach a separate page if more space is required.

Title	Name	Category of practice	Status (director, employee, contractor, room rental)	Avant member ID or name of other Insurer

22. Please complete the table below:

Staff type	# Employees (include part time and casual)	# Contractors
Nurse		
Nurse practitioner		
Midwife (non-intrapartum)		
Midwife (intrapartum)		
Technician		
Beautician		
Administration staff		
Management staff		
Total		

23. Are there any directors, employees, contractors who are registered health professionals that have conditions, limitations, or undertakings on their registration?  Yes     No

If **YES**, please provide details

24. Do you have written policies and/or procedures in place to cover the practice for employee terminations, harassment, anti-discrimination and equal opportunity issues that may arise?  Yes     No

If **NO**, please provide details of how human resources issues are managed by the practice

## Claims and insurance history

25. Has the practice held professional indemnity insurance in the past?  Yes  No

If **YES**, please provide details

Insurer	Policy period	Limit of indemnity	Deductible	Retroactive date

26. a) Have any medical indemnity claims been made against the practice during the last 10 years?  Yes  No

If **YES**, please provide details

Date of incident	Date of claim	Details of matter	Amount paid	Amount outstanding

26. b) After investigation with the employees, medical practitioners and anyone else engaged in the business, are you aware of any incidents or events which may lead to a claim or matter that could be covered by this policy?  Yes  No

27. Has the practice ever had an application or renewal for professional indemnity refused, a loading or special condition placed on insurance, or been offered or provided with a reduced level of cover?  Yes  No

If **YES**, please provide details

Insurer	Details of declinature, cancellation or special terms

## Insurance requirements

28. What date do you wish the policy to commence?  
Please note: If we approve your application and you then accept our offer of insurance, the insurance cover will start from the date we approve your application unless you request a later start date.

29. Please identify the limit of practice indemnity you require. If you require a higher limit than those listed below please contact us. Where no indemnity limit is selected, your quote will be provided on a \$5,000,000 indemnity limit.

\$5,000,000  \$10,000,000  \$20,000,000

30. Does the practice require retroactive cover?  Yes  No

If **YES**, what date do you want the retroactive cover to start from?

31. Does the practice require the following optional extensions (an additional premium will apply)?

Reinstatement (x1)?  Yes  No

Legal defence costs in addition to the limit of indemnity?  Yes  No

Public liability?  Yes  No

If **YES**, please complete addendum

**Public liability optional cover – addendum**

**Only complete this addendum if you require public liability cover.** The limit of public liability offered is \$20,000,000.

1. Please provide the following details of the buildings that are used by you

Building address	Age	Levels	Owner/leased

2. Are you currently located within another company’s public or private healthcare facility, including hospitals, day surgeries and where your reception area is located?  Yes  No

If **YES**, please provide details.

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3. Do you sub-contract out to other parties any functions of your business?  Yes  No

If **YES**, please provide details.

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4. Do you ensure that all sub-contractors have current liability insurance in place?  Yes  No

5. Do all premises comply with fire and evacuation procedures?  Yes  No

6. Please describe the fire protection and prevention procedures in place

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7. Do all premises comply with applicable laws of the Commonwealth and/or states or territories they are located within in relation to the following?	Disposal of sharps	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Disposal of hazardous waste	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Sterilisation of equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Do you perform any offsite activities (for example car parking, patient transport etc.)?  Yes  No

If **YES**, please provide details.

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9. Is there a written corporate policy which outlines the objectives and constraints of emission, waste and effluent management?  Yes  No

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10. Has the practice held public liability insurance in the past? If **YES**, please provide details.  Yes  No

Insurer	Policy period	Limit of indemnity	Deductible	Occurrence or claims made policy? (if claims made what is the retroactive date?)

11. Has the practice ever had an application or renewal for public liability refused, a loading or special condition placed on insurance, or been offered or provided with a reduced level of cover? If **YES**, please provide details.  Yes  No

Insurer	Details of declinature, cancellation or special terms

## IT Information

Does your practice engage an IT service provider?  Yes  No

Does your practice have multi-factor authentication in place for all remote user access to the practice?  Email only  Email and network  Network only  No

Does your practice have backups held offline from your network or in a cloud service designed specifically to be used for this purpose?  Yes  No

Do you utilise anti-virus software on all network endpoints, servers and access points?  Yes  No

## Electronic communications disclosure and consent Note: You may alter these consents at any time.

You will receive the policy wording and renewal documentation 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.

## Consent and declaration

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. You must also read the policy wording before signing the declarations.

### NSW stamp duty exemption declaration

If your practice is in NSW and you meet certain criteria, you may be eligible for stamp duty exemption on your practice insurance premium. I declare that:

I am a small business owner within the meaning of Section 152-10 (1AA) of the *ITAA 1997* of the Commonwealth for the income year in which the insurance is effected or renewed.  Yes  No

I am carrying on a business with a turnover of less than \$2 million in the last financial year.  Yes  No

I will undertake to inform you if my small business status changes in the future, i.e. if my turnover exceeds \$2 million per annum.  Yes  No

### Declaration of information

This declaration must be completed by either a director, chief executive officer, chief financial officer, practice manager or duly authorised person of the practice.

- I declare that:
- a) I am duly authorised by the practice to sign this proposal form on its behalf.
  - b) The information I have given in this application form and in any additional pages is true and correct, and I understand that Avant Insurance will rely on this information in deciding whether to provide the practice with an insurance contract and on what terms and conditions, and that it will form the basis of the policy.
  - c) I understand I have a duty under the *Insurance Contracts Act 1984* that means that before I enter into this Policy the practice must disclose to Avant Insurance every matter that the practice knows, or could reasonably be expected to know, that is relevant to Avant Insurance's decision to accept the Policy and, if so, on what terms and if the practice fails to comply with that duty Avant Insurance may refuse or reduce its liability for a claim or cancel the Policy. Full details of the duty of disclosure are set out in the policy wording. I have read and understood the Practice Medical Indemnity Policy wording. I acknowledge that if a contract of insurance is issued it will be subject to the terms and conditions of the policy wording provided to the practice or as otherwise specifically varied by Avant Insurance and agreed to by a duly authorised person of the practice.
  - d) I authorise Avant Insurance to obtain information or documents in relation to insurance matters or claims history from another insurance company, or an insurance reference bureau or similar organisation.
  - e) 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.

Signature		Position title	
Print name		Date	

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

**IMPORTANT:** Professional indemnity insurance products available from Avant Mutual Group Limited, ABN 58 123 154 898 (Avant) are issued by Avant's licensed subsidiary, Avant Insurance Limited, ABN 82 003 707 471, AFSL 238 765 (Avant Insurance). The information contained here is general advice only. You should consider the appropriateness of the advice having regard to your objectives, financial situation and needs before deciding to purchase or continuing to hold a policy with us. Please read and consider the policy wording. Your personal circumstances have not been taken into consideration. To obtain an accurate quotation an application form needs to be completed which is then subject to underwriting criteria and approval. The policy wording is available at [avant.org.au](http://avant.org.au) or by phoning 1800 128 268. MIM-1602 10/25 (MIM-1635)

Avant Insurance Limited ABN 82 003 707 471 AFSL 238765 is a subsidiary of Avant Mutual Group Limited ABN 58 123 154 898.

## Additional information

Section name	Section number	Additional details