

Alternative/Complimentary Medicines and Therapies Insurance Proposal Form

We will confirm the premium and period of insurance once we have reviewed your application

1. PERIOD OF INSURANCE

From: _____ To: _____

2. NAME OF YOUR PROFESSIONAL BODY International Institute for Complementary Therapists

Membership No. _____ Level of Membership: _____

3. YOUR DETAILS

First name: _____ Surname: _____

4. TRADING NAME (if applicable) _____

ABN: _____

5. POSTAL ADDRESS

Street: _____ Suburb: _____ City: _____

State: _____ Post code: _____ Country: _____

6. YOUR CONTACT DETAILS

Home Tel: _____ Fax: _____ Email: _____

Work Tel: _____ Website: _____ Mobile: _____

7. MODALITY(S) - ACCREDITED BY ABOVE PROFESSIONAL BODY

Modality(s)	(If practicing a beauty modality please advise % of your working time)

8. MODALITY(S) - NOT ACCREDITED BY ABOVE PROFESSIONAL BODY

Please attached copies of qualifications, for you and your employees, for all modality(s) listed above that are not accredited by your professional body

Modality(s)	% of time practiced	Qualifications	Where and When Obtained	Name of Accrediting Professional Body

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9. HAVE YOU OR ANY INSURED PERSON:

Sustained loss or damage or incurred liability, whether insured or not, of a type against which insurance is now sought?

Yes No

Had insurance declined or cancelled, had an insurer refuse to offer renewal, had special policy conditions imposed or had any claim rejected?

Yes No

Been declared bankrupt or put into receivership or voluntary liquidation?

Yes No

Been charged or convicted of any criminal offence?

Yes No

If you have answered yes to any of the above questions please provide details.

10. PLEASE INDICATE THE LIMITS YOU REQUIRE

For indicative pricing please refer to the Frequently Asked Questions and Insurance Fact Sheet

Public Liability \$10,000,000 \$20,000,000

Professional Indemnity and Products Liability \$1,000,000 \$2,000,000 \$5,000,000 \$10,000,000

11. DO YOU REQUIRE MULTI-PRACTITIONER COVER?

(A maximum of four practitioners, including the insured, can be covered by this policy)

Name of Practitioner	Modality(s)	Name of Accrediting Professional Body Contractor (Y/N)

12. DO YOU TEACH STUDENTS TO BECOME PROFESSIONAL PRACTITIONERS?

Yes No

If yes, please indicate the % of you working week spent teaching

0% - 10% of working time

11% - 30% of working time

31% - 50% of working time

13. DO YOU REQUIRE THE LEGAL POWER EXTENSION FOR AN ADDITIONAL PREMIUM?

Yes No

14. DO YOU REQUIRE COVER FOR GENERAL PROPERTY?

Yes No

This incurs an additional premium.

Please list the items you require for cover.

15. DO YOU REQUIRE THIS POLICY TO BE EXTENDED FOR RETROSPECTIVE LIABILITY?

Yes No

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DECLARATION IN RESPECT OF THIS PROPOSAL

After ENQUIRY, I DECLARE THAT:

1. I have made all necessary enquiries into the accuracy of the responses given in this Proposal.
2. The statements and particulars given in this Proposal are true and complete, and that no material facts have been omitted, misstated or suppressed.
3. Should any of the information given by me alter between the date of this Proposal and the inception date of any Insurance Policy, I will give immediate notice thereof to Insurer(s) via OAMPS, and I agree that Insurer(s) may alter or withdraw the terms that they have offered.
4. I agree that if there are any changes during the Policy Period to the declared Business Activities I will promptly notify Insurer(s) via OAMPS.
5. I have read and understood the Important Notices contained in this Proposal.
6. I agree that this Proposal, together with any additional information contained in an appendix or attachment, will form the basis of the contract of insurance effected by Insurer(s).
7. I agree that submitting this Proposal for the purposes of obtaining a quotation does not bind Insurer(s) to complete an Insurance Policy.
8. I will provide Insurer(s) with notice via OAMPS as soon as practicable of any fact or circumstance that might give rise to a Claim, and furnish all relevant documentation to Insurer(s), and that I will assist Insurer(s) in the investigation or defence of any Claim.
9. Insurer(s) are hereby authorised to make any investigation and inquiry in connection with this Proposal that they deem necessary.

Signature _____

Date _____



International
Institute for
Complementary Therapists

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