HEALTH PROFESSIONS INDEMNITY

PROFESSIONAL INDEMNITY INSURANCE APPLICATION

COMPULSORY TO BE A PSSA MEMBER

The insurance for which you are applying is managed and underwritten by PPS Health Professions Indemnity

Email application form to indemnity@pssa.org.za

Member Details **PSSA No:** (if available)

Surname:	Title:	Initials:	Full Names:	
ID No:	Date of Birth:		SAPC No: COMPULSARY	Maiden Name:
Home Tel:	Cell No:		E-Mail:	
Postal Address:				Code:
Street Address:				Code:

Employer Details

Full Name Of Practice Or Employer:		Y Number of Pharmacy:	
Postal Address of Employer:			Code:
Work Tel No:	Fax No:	E-Mail:	

Qualifications

Qualification:	Qualification Date:	Institution:

Incidents or Claims and Previous Insurance (COMPULSORY) – *please complete this section*

Details of any Errors / Omissions or Malpractice incidents, claims made or intimated against me:		
• Any claims made against the applicant during the last 10 years • Any circumstances / complaints which may give rise to a claim being made against the applicant	**Yes ☐** **Yes ☐**	**No ☐** **No ☐**
• Any application for insurance of this nature ever been declined, cancelled or has renewal been refused or have special terms been imposed	**Yes ☐**	**No ☐**
(If yes, attach details to application form)		

Split of Professional Services (Please indicate with a X)

If services are across both Private and State Owned facilities - split accordingly

Do you provide your services in **Private Facilities?** ☐ **YES** ☐ **NO**

If **YES,** What Percentage? ☐ Less than 25% ☐ More than 25% ☐ More than 50% ☐ 100%

Do you provide your services in **State Owned Facilities**? ☐ **YES** ☐ **NO**

If **YES,** What Percentage? ☐ Less than 25% ☐ More than 25% ☐ More than 50% ☐ 100%

1. Payment by Bank Debit Order raised by PPS Health Professions Indemnity:

Bank Name:								
Branch Name:								
Branch Code:								
Account Number:								
Type of Account:		Annually	☐	Monthly	☐	**1st**	☐	**15th** ☐
Name of Account Holder:								

I, _____ hereby authorise PPS Health Professions Indemnity to debit my bank account with the applicable fees. I confirm my membership of the Pharmaceutical Society of SA.

I declare and warrant that after enquiry all statements and particulars contained in this proposal and addenda are true and that no information whatever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I will advise the Underwriters as soon as possible. I understand that failure to disclose any material facts, which would be likely to influence the acceptance and assessment of the proposal, may result in the Underwriters refusing to provide indemnity or voiding the policy in every respect. I hereby agree and accept that this declaration shall be the basis of the contract between both parties if entered into.

Email application form to indemnity@pssa.org.za

SIGNATURE / AUTHORIZATION _____ **DATE** _____

HEALTH PROFESSIONS INDEMNITY

Title:	Initials:	Surname:	PSSA Number: (if available)

Rating Table for Individuals (Rates effective 01/04/2025)

Medical Malpractice & Professional Indemnity Only

Please indicate with a ✓ which option you choose.

						Cover limits	
	Disciplines	**Premium Annual**		**Premium Monthly**		**Each incident**	**Annual aggregate**
			✓		✓		
1	B. Pharm student	R100	☐		**N/A**	R5 million	R10 million
2	Interns and Community Service	R500	☐	R41.67	☐	R7.5 million	R10 million
3	Non-dispensing pharmacist (eg: Academic, Medical Scheme Administrators, DUR Pharmacists and other consultants)	R750	☐	R62.50	☐	R5 million	R10 million
4	State employed Dispensing and Compounding Pharmacist	R1 800	☐	R150.00	☐	R20 million	R20 million
5	Private Dispensing, Wholesale/Distribution and Industrial/Manufacturing Pharmacist	R2 350	☐	R195.83	☐	R20 million	R20 million
6	State employed Responsible Pharmacist	R2 450	☐	R204.17	☐	R20 million	R20 million
7	Private Responsible Pharmacist	R3 400	☐	R283.33	☐	R20 million	R20 million
8	S22A(15) permit holders (eg: PCDT), Private Compounding and Clinical Trial Pharmacist	R3 300	☐	R275.00	☐	R20 million	R20 million

1. All amounts are inclusive of VAT at 15%.
2. Premiums are annual amounts and can be paid either through a single payment or equal monthly payments.
3. All premium payments to be through debit order with premium payment a condition of cover.
4. *** Cover for Pharmacist Assistants and Technicians as well as Wound Care Nurses is only available through group pharmacy policies unless the individual in question qualifies for PPS Group membership.

I further understand that, should I not already be a member of the Professional Provident Society (PPS), the acceptance of this option will automatically grant me membership of PPS. As a graduate professional meeting the eligibility requirements of the Society, I am entitled to share in the benefits of the PPS product range, which includes insurance, investments and healthcare products. Following the registration, PPS will provide me with my unique membership number.

Email application form to indemnity@pssa.org.za

SIGNATURE **DATE**