MEDICAL PROTECTION SOCIETY
MEMBERSHIP APPLICATION

MAS – NEW ZEALAND
Scheme of co-operation

Medical Assurance Society — *We make it easy*

MPS

Please complete and return to: MPS c/o MAS Head Office, PO Box 13-015, 19–21 Broderick Road, Johnsonville, Wellington 6440.
If your application for membership of MPS is approved, it will be dated from the day following receipt of your application. If you would prefer it to commence from a later date please state: D D M M Y Y Y Y

Surname

Title

Forename(s)

Maiden or previous name **(if any)**

Date of birth D D M M Y Y Y Y

Gender **(Please tick)** ☐ Male ☐ Female

Nationality

Country of permanent residence

Country of practice

Address for correspondence

Postcode (zip code or postal area)

Telephone (Day)

Telephone (Evening)

Telephone (Mobile)

Fax no.

Email address: **(Please see declaration on page 3)**

Degrees and diplomas

Medical school

Month and year of graduation M M Y Y Y Y

Medical Council Registration no. and date of registration
Your application may be delayed if this is not provided

Any specialist registration

Main specialty

Date of specialist registration D D M M Y Y Y Y

Important information – please read

1. As part of our normal process, we may approach your previous indemnity or insurance organisation for your claims history. This process will take a minimum of 15 working days.
2. Failure to disclose full and accurate details about your previous history, practice and income may invalidate your membership which means you are not entitled to any advice or assistance from MPS.
3. When completing the previous history section on page 2 you must account for any gaps in your indemnity or insurance history from your date of graduation.
4. If you have had professional indemnity or insurance (other than from MPS) for any practice outside the United Kingdom you must obtain your case history to submit with this application.
5. As MPS provides occurrence based membership, we would not assist with any matter arising from an incident pre-dating your MPS membership.
6. If you are leaving a claims made insurance contract, please ensure you have notified your previous provider of any adverse incident of which you are aware, that could become a claim. You should also check with the provider whether any closing payment is required to secure "run-off" cover for any future claim which may arise from an incident pre-dating your MPS membership.

   Please note that signing the declaration on page 3 indicates acceptance of the following requirements:
   Members undertake to keep MPS informed of their current address and any changes in their professional circumstances. Failure to notify us of any change of address or scope of practice could result in the suspension of the benefits of membership and/or the termination of your membership. Members should understand that MPS is not an insurance company. The benefits of MPS membership are granted at the discretion of Council and are subject to the terms and conditions of the MPS Memorandum and Articles of Association, as amended from time to time.

MAS office use only

Date received: D D M M Y Y Y Y

Approved by:

Membership no.

Start date: D D M M Y Y Y Y

Previous history

In this section you must include details of any matter in which you have been named or involved. Please include any pending, unresolved or closed issues, even those already reported to MPS.

1. Have you had any professional indemnity/insurance before?
   - ☐ Yes (Please answer all questions below.)
   - ☐ No (Please answer questions 5–11.)

2. Please give the name of all organisation(s) and the dates during which you were a member or policyholder.*

   Organisation: From: To: Membership/Policy number:

3. If you were previously a member of MPS, please give your membership number and your name at the time (if it has changed).

   Name: Membership number:

4. Have there been any gaps in your professional indemnity/insurance since the date of your graduation? (If in doubt please indicate YES.)
   - ☐ Yes (Please give dates and details below)*
   - ☐ No

5. Have you ever been refused professional indemnity/insurance, including refusal to renew or been offered limited or conditional terms?
   - ☐ Yes (Please give dates and details below)*
   - ☐ No

6. Have you ever been the subject of any complaint arising out of your professional practice? (If in doubt please indicate YES.)
   - ☐ Yes (Please give dates and details below)*
   - ☐ No

7. Have you ever been involved in any claim for compensation arising out of your professional practice or are you aware of any incident that might become a claim? (If in doubt please indicate YES.)
   - ☐ Yes (Please give dates and details below)*
   - ☐ No

8. Have you ever been the subject of a disciplinary inquiry by your employer or had practice privileges refused/withdrawn/made conditional by a private health provider? (If in doubt please indicate YES.)
   - ☐ Yes (Please give dates and details below)*
   - ☐ No

9. Have you ever been subject to any complaint, inquiry or investigation or hearing by your registration body or had conditions imposed on your practice or been suspended or erased from a medical register? (If in doubt please indicate YES.)
   - ☐ Yes (Please give dates and details below)*
   - ☐ No

10. Have you ever been cautioned by the police in respect of, or convicted of, any criminal allegation (including road traffic offences)?
    - ☐ Yes (Please give dates and details below)*
    - ☐ No

11. Are there any other issues related to your professional conduct or competence of which MPS might reasonably need to be aware when considering your application for membership? (If in doubt please indicate YES.)
    - ☐ Yes (Please give dates and details below)*
    - ☐ No

* Please continue on a separate sheet if necessary.

Declaration

I wish to apply for membership of MPS subject to the Memorandum and Articles of Association and upon payment of the appropriate subscription.

I understand that membership is not conferred automatically and is subject to approval. I consent to MPS seeking information regarding past and current matters from other professional protection bodies, insurance companies or employers with whom I have had professional indemnity arrangements, and to the release of that information to MPS. I consent to MPS processing information about me. (Please see data protection information below.)

I consent to MPS using the email address provided for communication with me.

I confirm that the information I have provided is correct to the best of my knowledge and that I have read the notes and information above. **I also confirm that I have completed the payment instruction below.**

PLEASE NOTE

- It is your responsibility to provide accurate information about your professional practice, and relevant income (which may affect the subscription you pay). Failure to notify us of any change of address or scope of practice could result in the suspension of the benefits of membership and/or the termination of your membership.

Signature

Date

D D / M M / Y Y Y Y

Data protection information

We will process the information you provide on our systems for administration of your membership and claims, and for underwriting, marketing, risk assessment, research and advisory purposes. We may disclose your information to legal or other professional advisers or other medical protection organisations as part of our advisory and claims-handling process, as well as to third parties who assist with member services.

By signing this form or completing it online you consent to the processing of personal data, including sensitive personal data for the purposes outlined above.

You have the right under the Data Protection Act to obtain disclosure of personal data that we have relating to you, for which we make a nominal charge.

In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. If you do not wish to receive such information, either via post or email, please tick this box. ☐

Why MPS membership?

Why have you chosen to apply for MPS membership? (Please circle)

1 Personal recommendation

2 Competitive subscription rates

3 Group arrangement

4 Dissatisfaction with previous organisation

5 Other (please give details in the space provided)

MPS – New Zealand
Contact information

c/o MAS
Medical Assurance Society Head Office,
PO Box 13-015,
19–21 Broderick Road,
Johnsonville,
Wellington 6440.

Telephone 0800 225 5677 (FREEPHONE)
Facsimile 04 494 7010
Email membership@mps.org.nz
Website www.medicalprotection.org/newzealand

MEDICAL PROTECTION SOCIETY
Granary Wharf House, Leeds LS11 5PY, UK
International telephone +44 (0) 113 243 6436
Facsimile +44 (0) 113 241 0500

www.medicalprotection.org
international@mps.org.uk

MEDICAL PROTECTION SOCIETY

MAS – NEW ZEALAND
Subscription payment instruction

Medical Assurance Society — *We make it easy*

MPS

I wish to pay my subscription (including 12.5% GST) in accordance with the indicated payment method below:

Signature

Date D D M M Y Y Y Y

Please note: By completing this form I understand that if my subscription or any other liability to MPS is in arrears for more than one month, then I shall cease to be entitled to any membership benefit from MPS from that date when such subscription or liability fell due. I also understand that after non-payment for two months MPS may terminate my membership by notice, although my liability to MPS already accrued will not be affected.

What to do now:

Step 1: Check what your MPS subscription rate should be, using the current MPS subscription rates as enclosed.

Step 2: Indicate the amount of your subscription and your preferred method of payment opposite.

Step 3: Either write your cheque or provide your card authorisation or complete the direct debit instruction.

Step 4: Return the whole form and any enclosures to:
MPS c/o MAS Head Office, PO Box 13-015,
19–21 Broderick Road, Johnsonville, Wellington.

I wish to pay my subscription of:

- by annual direct debit ☐ on or just after the next available 1st of the month.
- by monthly direct debit ☐ on or just after the 1st of the month, in months 2–11 (inclusive) of the subscription year.
- by cheque (in full) ☐ cheques should be crossed and made payable to The Medical Protection Society Limited.
- by credit/debit card (in full) ☐ enter your card number below. **MPS does not accept American Express or Diners Card.**

Important information – please read

- It is your responsibility to provide accurate information about your professional practice and relevant income (which may affect the subscription you pay). Failure to notify us of any change of address, private practice income and scope of practice could result in the suspension of the benefits of membership and/or the termination of your membership.

MPS office use only

Expiry date D D M M Y Y Y Y

Cardholder's name and address

Cardholder's signature

Direct Debit (Please complete shaded areas)

Membership Number

Name of Bank Account Holder:

Customer to complete bank/branch number and account number and suffix of account to be debited

Bank | Branch Number | Account Number | Suffix

Name of Bank and Branch

Authority to accept Direct Debits
(Not to operate as an assignment or an agreement)

Authorisation Code: 0618446

Date / /

I/We authorise you until further notice in writing to debit my/our account with you all amounts which Medical Assurance Society, New Zealand Limited (hereinafter referred to as the Initiator), Head Office, PO Box 13-015, 19-21 Broderick Road, Johnsonville, Wellington. Telephone 0800 225 5677, Facsimile (04) 494 7010, the registered Initiator of the above Authorisation Code, may initiate by Direct Debit.

I/We acknowledge and accept that the bank accepts this authority only upon the conditions overleaf.

Information to appear in my/our bank statement (to be completed by the Customer)
Payer particulars

Authorised signature(s):

Date:

FOR BANK USE ONLY

Original – Retain at Branch

Duplicate – Forward to Initiator if requested

Date received: | Recorded by: | Checked by:

Bank Stamp

MPS – New Zealand
Contact information

c/o MAS
Medical Assurance Society Head Office,
PO Box 13-015,
19–21 Broderick Road,
Johnsonville,
Wellington 6440.

Telephone 0800 225 5677 (FREEPHONE)
Facsimile 04 494 7010
Email membership@mps.org.nz
Website www.medicalprotection.org/newzealand

MEDICAL PROTECTION SOCIETY
Granary Wharf House, Leeds LS11 5PY, UK
International telephone +44 (0) 113 243 6436
Facsimile +44 (0) 113 241 0500

www.medicalprotection.org
international@mps.org.uk

Conditions of Direct Debit Authority

1. The Initiator:

(a) The Initiator undertakes to give written notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the first Direct Debit is drawn (but not more than 2 calendar months). In the event of any subsequent change to the frequency or amount of the Direct Debits, the Initiator has agreed to give written advance notice at least 30 days before the change comes into effect.

(b) May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. Upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.

2. The Customer may:

(a) At any time terminate this Authority as to future payments by giving written notice of termination to the Bank and the Initiator.

(b) Stop payment of any Direct Debit to be initiated under this Authority by the Initiator by giving written notice to the Bank prior to the Direct Debit being paid by the Bank.

(c) Where a variation to the amount agreed between the Initiator and the Customer from time to time to be direct debited has been made without notice being given in terms of clause 1(a) above, request the Bank to reverse or alter any such Direct Debit initiated by the Initiator by debiting the amount of the reversal or alteration of a Direct Debit back to the Initiator through the Initiator's Bank PROVIDED such request is not made more than 120 days from the date when the Direct Debit was debited to my/our account.

3. The Customer acknowledges that:

(a) This authority will remain in full force and effect in respect of all Direct Debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the Bank.

(b) In any event this authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

(c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the Direct Debit has not been paid in accordance with this authority. Any other disputes lie between me/us and the Initiator.

(d) Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility or liability in respect of:

– the accuracy of information about Direct Debits on Bank statements.

– any variations between notices given by the Initiator and the amounts of Direct Debits.

(e) The Bank is not responsible for, or under any liability in respect of the Initiators failure to give written advance notice correctly nor for the nonreceipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.

(f) Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

4. The Bank may:

(a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.

(b) At any time terminate this authority as to future payments by notice in writing to me/us.

(c) Change its current fees for this service in force from time-to-time.