# MEMBERSHIP APPLICATION SCHEME OF CO-OPERATION SINGAPORE

800 616 7055 | mps@sma.org.sg | medicalprotection.org

Medical Protection

Please complete in BLOCK CAPITALS, sign and return to: **Singapore Medical Association, 2985 Jalan Bukit Merah, #02-2C SMF Building, Singapore 159457**. For enquiries telephone 800 616 7055 or email: mps@sma.org.sg.

If your application for membership of MPS is approved, it will be dated from the day following receipt of your application unless you specify a later start date in the the area provided:

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## Personal details

Title

First name

Surname

Maiden/previous name if any

Date of birth (DD/MM/YYYY)

Gender ☐ Male ☐ Female

Nationality

NRIC/FIN/Passport number

Country of practice

Country of permanent residence

Address for correspondence

Postcode (zip or postal area)

Daytime telephone

Evening telephone

Mobile number

Fax number

Email address

Membership category **(see page 4)**

Degrees and diplomas

Medical school and country

Month and year of graduation (MM/YYYY)

Singapore Medical Council registration number and date of registration (DD/MM/YYYY) – your application may be delayed if this is not provided

Any specialist registration

Main specialty

Date of specialist registration (DD/MM/YYYY)

## IMPORTANT! – Please read the following

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 and practice may invalidate your membership which means you are not entitled to seek advice or assistance from MPS.
3. When completing the previous history section on pages 2 and 3 you must account for any gaps in your indemnity or insurance history during the last 10 years and also any break in clinical practice during the previous 2 years.
4. We will not assist with any matter arising from an incident pre-dating your MPS membership.
5. 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 5 indicates acceptance of the following requirements:**
Members must 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 and/or the withdrawal of the benefits of membership and/or the cancellation and/or the termination of your membership. 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.

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**PLEASE READ THE IMPORTANT INFORMATION BELOW**

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. If necessary please continue your answers on the enclosed pages. Please note that failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

1. **Have you had any professional indemnity/insurance before?** ☐ **Yes** (Please go to Q2) ☐ **No** (Please go to Q3)

2. **Please give the name of all other organisations and the dates during the last 10 years which you were a member or policyholder. If you were previously a member of MPS, please give your membership number and your full name at the time** (if it has changed).

| Organisation | From DD/MM/YYYY | To DD/MM/YYYY | MPS number | Full Name | Other membership or policy number |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

3. **Have you at any stage practiced without professional indemnity during the last 10 years (ie, Please exclude any period(s) protected by state, employer, insurer or MDO indemnity)?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reasons below.

☐ Yes ☐ No

4. **Have there been any breaks in your clinical practice of more than 6 months in the last 2 years?** (If in doubt please indicate YES.) If you answer YES please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken.

☐ Yes ☐ No

5. **Have you ever previously been refused professional indemnity/insurance including a decline to renew or had it withdrawn/voided?** (If in doubt please indicate YES.) If you answer YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence.

☐ Yes ☐ No

6. **Have you had any non-standard terms or conditions including a non-standard subscription or premium imposed on your professional indemnity/insurance?** If you answer YES please provide date and full details. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

7. **In the last 10 years, have you had any complaint(s) arising out of your professional practice which has not been resolved at a local level (ie, within your own practice)?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

If you have answered YES to any of the above questions please provide details as requested. Use the enclosed pages if needed and include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

8. **In the last 10 years have you been involved in any claim(s) for compensation or damages arising out of your professional practice regardless of the outcome?** If you answer YES please provide full details of the complaint(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the incident. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

9. **Are you aware of any incident(s) that might become a claim?** If you answer YES please provide full details of the incident(s). The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the current status of the incident(s). (If necessary please continue on a separate sheet)

☐ Yes ☐ No

10. **Have you ever been the subject of a disciplinary inquiry or had practice privileges refused/ withdrawn/ made conditional by a health care provider?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the incident(s) occurred, name of indemnifier, the final outcome of the incident and was this reported to the regulatory body. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

11. **Have you ever been subject to any referral, complaint, inquiry, investigation or hearing by any regulatory, licensing or registration body?** If you answer YES please provide full details. The details must include: date of incident, factual summary of the event, the extent of your involvement, country where the case was lodged, name of indemnifier and the final outcome of the case. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

12. **Have you been cautioned by the police or convicted of any criminal offence? (You do not need to include spent/expired convictions, or minor road traffic offences that did NOT involve alcohol or drugs.)** If you answer YES please provide full details. The details must include: date of incident, full details of the offence, the final outcome or current position and was this reported to the regulatory body. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

13. **Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership?** (If in doubt please indicate YES.) If you answer YES please provide all relevant information below. (If necessary please continue on a separate sheet)

☐ Yes ☐ No

**If you have answered YES to any of the above questions please provide details as requested. Use the enclosed pages if needed and include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.**

## Section C – Practice details

**If you are registered to practise in any other Country please state which:**

Will all your professional practice be carried out in the Country in which you are applying for membership?

☐ Yes ☐ No If **No**, please provide Country and full details (If necessary please continue on a separate sheet)

**Will you be involved in treating or providing advice to patients outside of the Country in which you are applying for membership? (eg, telemedicine)**

☐ Yes ☐ No If **Yes**, please provide Country and full details (If necessary please continue on a separate sheet)

What is your current professional status?

What is your current specialty?

**Please indicate your medical status (as per current MPS subscription categories)**

- ☐ Low risk
- ☐ Medium risk
- ☐ High risk
- ☐ Very high risk
- ☐ Super high risk
- ☐ Cosmetic/aesthetic surgery
- ☐ Obstetric
- ☐ Non-Clinical **(Please provide details of your practice in writing)**
- ☐ House Officer
- ☐ Medical Officer
- ☐ Registrar
- ☐ Fellow
- ☐ Family medicine procedural
- ☐ Family medicine non-procedural
- ☐ Cosmetic/aesthetic medicine
- ☐ Singapore Armed Forces Medical Officer (F/T training)
- ☐ Singapore Armed Forces Medical Officer (Regular) **High risk**
- ☐ Singapore Armed Forces Medical Officer (Regular) **Medium risk**
- ☐ Singapore Armed Forces Medical Officer (Regular) **Low risk**
- ☐ Other **(Please specify):**

## IMPORTANT! – Your Personal Information and Data

When interacting with MPS, you may choose to give MPS information about your criminal convictions and offences (including alleged offences), your health, race, ethnic origin, sex life, sexual orientation and trade union membership ("Special Category Data"). This happens where that information is relevant to your membership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about you from others in connection with membership or advice, assistance or indemnity (e.g. from a complainant, claimant, witness, expert, court or regulator).

To find out more about how we collect, use and handle your data including Special Category Data, please see the Privacy Statement on our website **dentalprotection.org**.

**When you tick the box below, you expressly consent to MPS processing your Special Category Data for the purposes of providing you with membership and its benefits (including assistance and indemnity).**

☐ **I consent**

You may withdraw consent to such processing by contacting MPS, but if you do so we will no longer be able to provide you with membership and its benefits.

## IMPORTANT! – Please read, sign and add the current date below.

By signing and returning this form, you agree and confirm that:

(i.) You wish to apply for membership of MPS subject to the Memorandum and Articles of Association

(ii.) You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership

(iii.) You understand that membership is not conferred automatically and is subject to approval by MPS

(iv.) You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS does not of itself confirm membership and/or entitlement to request benefits

(v.) You will inform us if your personal circumstances or scope of practice change

(vi.) We may seek information from other professional defence organisations, insurance companies, employers, and/or other third parties in respect of membership and that they may release to us such information

(vii.) For the purposes of the Singapore law and The Personal Data Protection Act 2012, we may obtain, process, retain and transfer your personal data as set out in the Privacy Statement on our website **dentalprotection.org/**

**Date** D D M M Y Y Y Y **Please note must be current date**

☐ If you are submitting additional sheets or correspondence, please tick here

☐ Please check that you have completed a payment instruction form telling us how you would like to pay for your subscription and please tick here to confirm that the form is enclosed

☐ 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. To opt-in to receive such information, either via post or email, please tick here.

You can update your marketing preferences by contacting us.

### Medical Protection – Singapore contact information

c/o Singapore Medical Association
2985 Jalan Bukit Merah
#02-2C SMF Building
Singapore 159457

**T** 800 616 7055

**mps@sma.org.sg**
**medicalprotection.org/singapore**

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## Method of payment

Step 1: Check what your Medical Protection subscription category should be, please contact your local membership advisor.

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

Step 3: Write your cheque.

Step 4: Sign, date and return this payment instruction with your application form to:
**Singapore Medical Association, 2985 Jalan Bukit Merah, #02-2C SMF Building, Singapore 159457.**

☐ Cheque (in full) – made payable to The Medical Protection Society Limited S$

**Signature:** **Date:** (DD/MM/YYYY)

**Please note:** It is your responsibility to provide accurate information about your professional practice. Failure to notify us of any change of address, private practice income and scope of practice could result in the suspension and/or with withdrawal of the benefits of membership and/or the cancellation and/or the termination of your membership.

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.

**Signature:** **Date:** (DD/MM/YYYY)

**OFFICE USE ONLY**

| |
|---|
| Date received |
| Amount (S$) |
| Cash/Cheque/MO/PO |
| Issued by (name) |
| Date of receipt |
| Membership number |
| Start date |

## Medical Protection – Singapore contact information

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Singapore 159457

**T** 800 616 7055

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**medicalprotection.org/singapore**

## Please tell us why you have chosen MPS – Your comments are important to us, please tick below

1. ☐ Personal recommendation
2. ☐ Competitive subscription rates
3. ☐ MPS membership co-ordinator, please provide their initials:
4. ☐ Group arrangement
5. ☐ Dissatisfaction with previous organisation
6. ☐ Other (please provide details in the space provided)

## Additional space for answers to Sections

Please clearly indicate the question number that you are providing details for below.

**Please attach additional pages if necessary and clearly indicate the question number for which you are providing additional information. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.**

## Additional space for answers

Please clearly indicate the question number that you are providing details for below.

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