

# APPLICATION FOR MEMBERSHIP AUSTRALIAN DENTAL ASSOCIATION (WA BRANCH) INC

**IMPORTANT: PLEASE READ CAREFULLY TO ENSURE ALL  
FORMS HAVE BEEN COMPLETED IN FULL.**

## **CHECKLIST**

I have:

- Completed and signed the ADA WA Application for Membership form, including obtaining the signatures of a Proposer and Seconder.
- Completed and signed the Dental Protection Application for Scheme Membership form and circled my Membership Category.
- Completed and signed the MDA National Proposal for Dental Indemnity Policy.

If you are unsure of any of the questions, **PLEASE** phone the Membership Officer, Sue Hurley on (08) 9211 5678 for instructions.

Please post completed forms to:

**Ms Sue Hurley  
Membership Officer  
ADA (WA Branch) Inc  
PO Box 34  
West Perth WA 6872**

**OR** scan completed forms and email to [admin@adawa.com.au](mailto:admin@adawa.com.au)

# APPLICATION FOR MEMBERSHIP (CONFIDENTIAL)



INCLUDING APPLICATION FOR MEMBERSHIP OF THE AUSTRALIAN DENTAL ASSOCIATION INC.  
(Please use **BLOCK LETTERS**)

Title	Family Name		
Preferred Name	Given Names	Date of Birth / /	Sex

Principal Practice Address (Street Number and Name)		Telephone	
(Suburb)	Post Code	Facsimile	
Postal Address (if different from street address)			Post Code

Home Address (Street Number and Name)		Telephone	
(Suburb)	Post Code	Mobile	

Other Practice(s) (Street Number and Name—attach list if necessary)		Telephone	
(Suburb)	Post Code	Facsimile	
Postal Address (if different from street address)			Post Code

E-mail Address
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Please forward mail to:     Principle Practice     Home     PO Box

Practice Particulars (tick all relevant boxes)

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Private Practice                                | <input type="checkbox"/> Government         | <input type="checkbox"/> University    | <input type="checkbox"/> Overseas     |
| <input type="checkbox"/> Student 1 <sup>st</sup> to 3 <sup>rd</sup> Year | <input type="checkbox"/> Student Final Year | <input type="checkbox"/> Post-Graduate | <input type="checkbox"/> Incorporated |
| <input type="checkbox"/> Sole Practitioner                               | <input type="checkbox"/> Associateship      | <input type="checkbox"/> Employee      | <input type="checkbox"/> Armed Forces |
| <input type="checkbox"/> Partnership                                     | Name of Partner(s) .....                    |  |                                       |
| <input type="checkbox"/> Specialist                                      | Type of Specialty .....                     |  |                                       |
| <input type="checkbox"/> Practising Spouse                               | Name ..... (optional)                       |  |                                       |
| <input type="checkbox"/> Limited Practice                                |   |  |                                       |

University of Graduation (attach list if insufficient space)		Year of Graduation
Degrees and Awards (attach list if insufficient space)	Date of Registration with Dental Board of WA:	Dental Board Registration No.

<b>CURRENT PROFESSIONAL INDEMNITY COVER</b>	
Name of Company	
Indemnity Valid from:    /    /    to:    /    /	

# APPLICATION FOR MEMBERSHIP (CONFIDENTIAL)



APPLICATION FOR MEMBERSHIP (continued)

## DECLARATION:

1. I, ..... hereby apply to become a member of the Australian Dental Association (WA Branch) Inc (ADA(WA)). I have read and understand the Constitution, Rules and Code of Ethics and agree to be bound by the Constitution, Rules and Code of Ethics made by the Association or the Council and undertake at all times to uphold the professional and ethical obligations of membership.
2. I understand that election to membership of ADA(WA) also includes membership of the Australian Dental Association Inc. (Federal), by virtue or requirements under the Constitution, Rules and Code of Ethics of the ADA(WA).
3. I further understand that my membership of ADA(WA) as an Active Member is conditional on my acceptance of membership with Dental Protection Limited (a division of the Medical Protection society Limited), or such indemnity as the ADA(WA) may require from time to time. Such membership to be effected not later than the expiration of my current indemnity cover subscription period or twelve months, whichever is the sooner. I wish to become a member of the Medical Protection Society Limited upon the terms of Memorandum and Articles of Association of the Society. Exception of this regulation may be granted by Council.

**A copy of the Constitution, Rules and Code of Ethics of the ADA(WA) may be perused at the offices of the ADA(WA), 54-58 Havelock Street, West Perth, WA or downloaded from the website [www.adawa.com.au](http://www.adawa.com.au) .**

Dated this ..... day of ..... 20.....

Signature .....

## NOMINATION OF APPLICANT (please use BLOCK LETTERS)

We, the undersigned, hereby nominate ..... to be elected as a member of the Australian Dental Association Western Australian Branch Inc., and the Australian Dental Association Inc. and support this application.

**Signature of Proposer** .....

Name ..... Telephone ( ).....

Address .....

Personal knowledge of applicant  Yes  No

**Signature of Seconder** .....

Name ..... Telephone ( ).....

Address .....

Personal knowledge of applicant  Yes  No

**NOTE: Both the Proposer and the Seconder are required to be current members of the ADA(WA).**

RETURN TO: PO BOX 34, WEST PERTH WA 6872

# Application for Scheme Membership - Australia

Dental Protection



Dental Protection Limited & The Medical Protection Society

**FOR DENTISTS & SPECIALISTS, ORAL & MAXILLOFACIAL SURGEONS**

## Personal Details

Title:  Dr  Prof  Ms  Miss  Mrs  Mr  Male  Female

Surname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Given Names: \_\_\_\_\_ Nationality: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Mobile: \_\_\_\_\_

Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

Year of Qualification: \_\_\_\_\_ Location: \_\_\_\_\_

Additional Qualifications: *(give year and conferring body)* \_\_\_\_\_

Dental Board Registration No: \_\_\_\_\_

Please circle area of work:  Private Practice /  Hospital /  Defence Forces /  Laboratory /  Other

*(Give details if other):* \_\_\_\_\_

Specialty *(if applicable)*: \_\_\_\_\_

Registerable Qualification: \_\_\_\_\_

I require membership from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ *(Enter Date)*

Your membership is provisional for 30 days from this date entered.

## MEMBERSHIP DECLARATION - TO BE COMPLETED BY ALL APPLICANTS

I wish to apply for Scheme membership of the Medical Protection Society (MPS) ARBN 005 885 017 (incorporated in the United Kingdom) upon the terms of the Memorandum and Articles of Association from time to time in force (copies of which are available on request).

I understand that if my subscription or any other liability to DPL/MPS is in arrears for more than one month, then I shall cease to be entitled to any membership benefits from DPL/MPS from the date when such subscription or liability fell due. I also understand that after non-payment for 2 months DPL/MPS may terminate my membership by notice, although any liability to DPL/MPS already accrued may not be affected.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NB:** It is essential that you immediately advise ADA (WA Branch) Inc if you change the Country/State in which you practice or the details of your professional practice alter in any way, as this may affect the amount of subscription/premium paid and your entitlement to the benefits of membership.

In order to comply with the Medical Indemnity (Prudential Supervision and Products Standards) Act 2003, and other legislative requirements in Australia ("The relevant Acts") DPL members are offered claims made insurance from MDA National Ltd which is wholly owned by the MDA National Limited (MDA National).

To receive an offer of insurance you must first be a member of ADAWA and of Dental Protection Limited. Please complete this application form in detail together with the application form and return to:

**ADA (WA Branch) Inc, PO Box 34, West Perth WA 6872.**  
Phone: (08) 9211 5678 Fax: (08) 9321 1757 Email: [admin@adawa.com.au](mailto:admin@adawa.com.au)

**IMPORTANT:** The offer and completion of this application form does not imply an acceptance into membership, which remains at the discretion of Dental Protection Limited.

# Dental Practitioner Proposal for Dental Indemnity Policy

This is a proposal for a Dental Indemnity Policy underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073.

In completing this proposal, 'we', 'our' and 'us' means MDA National Insurance. 'You' and 'your' means the proposed insured.

It is important that all information contained in this proposal is accurate and complete as this document will form the basis of the insurance contract between you and us. Where there is not sufficient room, please provide your answer on a separate attachment. Failure to disclose all material information that is likely to influence the acceptance of the risk or the terms applied could invalidate the insurance contract. If you have any doubt as to whether any information is material, it should be disclosed. **Please read the Important Notice on page 4 before completing this form. Please ensure that you read and understand the terms and conditions of the Dental Indemnity Policy as outlined in the Dental Indemnity Policy Important Information and Policy Wording, and any Supplementary Important Information and Endorsement to Policy Wording.**

**Where you have an obligation to notify the insurer of a matter, this matter can be advised to the relevant Corporate Authorised Representative of the insurer. Please contact the association or organisation that arranges your indemnity insurance to notify any matters under this policy.**

Note: The issue of a policy is subject to our underwriting approval.

## 1. Personal Details

Title	Date of birth	/	/
First name(s)	Middle name(s)		
Surname			
Former name/Maiden name	<input type="checkbox"/> Male		<input type="checkbox"/> Female
Mailing address			
	State		Postcode
Primary practice address			
	State		Postcode
Home telephone ( )	Practice telephone ( )		
Facsimile ( )	Mobile		
Email			

### Corporate Authorised Representatives:

**Australian Dental Association (WA Branch) Limited** CAR No. 326133 | Phone: (08) 9211 5678 | Fax: (08) 9321 1757

**Dental Protection Limited Australia Pty Ltd** CAR No. 326134 | Freecall: 1800 444 542 | Fax: (07) 3831 7255

MDA National Insurance Pty Ltd ABN 58 056 271 417 AFS Licence No. 238073.

## 2. Policy Coverage Requirements

- 2.1** When would you like your cover to commence? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 2.2** What is your practice category code?  
Please refer to the Practice Category Guide to determine your appropriate practice category. If you have any questions in relation to the practice categories, please contact the relevant association or organisation that arranges your indemnity insurance. \_\_\_\_\_
- 2.3** Do you act, or are you likely to act, in the capacity of a Medical Practitioner (outside of dentistry) at any time in the insurance year?  YES  NO  
If YES, please provide details of the nature of the medical practice undertaken on a separate attachment.

## 3. Retroactive Cover for Past Practice

- 3.1** When did you first commence practice as a Dental Practitioner in Australia? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 3.2** Please provide details of your previous insurers or medical defence organisations for the last 10 years in the table below. If you require additional space please complete on a separate attachment.

Name of Organisation/Insurer	Period of Insurance	Retroactive date* on Policy

Please read the information below to obtain an understanding of what retroactive cover is. If you have any questions or are unsure about how to complete this section, contact the association or organisation that arranges your indemnity insurance.

\*The retroactive date determines how much of your prior practice is covered under your policy. If your previous insurance policy specifies "Unlimited" for the retroactive date, your MDA National Dental Indemnity Policy will cover you for new matters that you become aware of, arising from your past practice in Australia, irrespective of how long ago the incident occurred. If your previous policy shows a specific retroactive date, please state the date. Your MDA National Insurance Dental Indemnity Policy will not respond to any matter arising out of an incident that occurred before that retroactive date.

## 4. Qualifications and Registration

Qualification	Institution	Year
Qualification	Institution	Year
Dental Board Registration Number	Date First Registered in Australia	_____ / _____ / _____

- 4.1** Have you ever been refused registration, deregistered or suspended from practice as a dental practitioner whether as a result of a disciplinary proceeding or otherwise?  YES  NO  
If YES, please provide full details on a separate attachment.
- 4.2** Do you currently have, or have you ever had, conditions, undertakings, reprimands or notations placed on your registration?  YES  NO  
If YES, please provide a copy of these conditions.

## 5. Claims and Indemnity History

- 5.1** Have you ever been refused membership of a Medical Defence or Dental Indemnity Organisation, been refused professional indemnity, had your insurance or membership cancelled or not been offered renewal?  YES  NO
- 5.2** Has any Medical Defence or Dental Indemnity Organisation or insurer ever imposed any non-standard terms or conditions on your practice or professional indemnity cover, including any requirement that you participate in a risk management program, or have they advised you that such requirements, terms or conditions will be imposed on your current or future indemnity or practice?  YES  NO
- 5.3** Have you ever had any claims made or threatened against you or against a current or previous employer arising from your provision of dental services, whether finalised or not?  YES  NO
- 5.4** Are you aware of any circumstances which may give rise to a claim against you or a current or previous employer arising from your provision of dental services?  YES  NO
- 5.5** Have you ever had any complaints made or threatened against you arising from your provision of dental services, whether they have been investigated or not?  YES  NO
- 5.6** Have you ever been the subject of an investigation, complaint, disciplinary or other proceeding or inquiry by any hospital, tribunal, professional registration board, court, statutory body (including but not limited to Medicare) or any other body?  YES  NO
- 5.7** Have you ever been the subject of a criminal investigation or had criminal charges laid against you? For the purposes of this question, please disregard traffic or minor motor vehicle licensing offences.  YES  NO
- 5.8** Whilst working as a dental practitioner have there been any gaps in your professional indemnity/insurance since the date of your graduation?  YES  NO

If you are aware of any claims, investigations or inquiries or circumstances which may result in a claim, complaint, investigation or inquiry, please ensure that you notify your current insurer prior to submitting this application. If you have answered YES to any question in this section, please provide a detailed description of each matter on a separate attachment. WE MAY REQUIRE YOU TO OBTAIN A FULL CLAIMS HISTORY FROM CURRENT AND PREVIOUS INSURERS. For questions relating to claims, circumstances, inquiries or investigations please include in this description:

- whether the matter was notified or dealt with by an insurer and, if so, which organisation;
- the date of the incident;
- a brief summary of the matter and the relevant details (if the matter involved a patient please do not identify the patient in any way);
- your involvement in the matter;
- details of any legal or indemnity payments made, if you are aware of this;
- the outcome if known (if unknown, please state the last known status).

**PLEASE DO NOT SEND ANY ORIGINAL DOCUMENTS WITH THIS PROPOSAL**

## 6. Declaration - must be signed and dated

### I declare that:

1. I agree to be bound by the terms and conditions of the policy.
2. I have read and understood the Important Notice and contents of this proposal and acknowledge that the information included in, or attached to, this form is accurate and complete.
3. I understand my duty of disclosure exists until the contract of insurance is entered into and that I have a continuing obligation to inform MDA National Insurance or its Corporate Authorised Representatives of any material alteration of the risk during the period of insurance including any change in my field of practice or any material change in the nature of professional services provided by me, or the risk category that I have previously declared.
4. I acknowledge that the policy (if issued) will not indemnify me with respect to:
  - (a) claims that have been made against me as at the date of this proposal;
  - (b) claims that arise in the future from matters that I am aware will likely give rise to a claim as at the date of this proposal;
  - (c) any current investigation or inquiry;
  - (d) any future investigation or inquiry that results from a matter that has been, or is currently being, investigated or matters that I am aware of as at the date of this proposal that will be the subject of an investigation or inquiry; and
  - (e) any matter reported on or with this proposal or matters that should have been reported on or with this proposal.

### Authorisation and Consent:

5. I authorise and request any Dental Board or other registration body to release all information requested by MDA National Insurance regarding my registration as a dental practitioner, any conditions placed on it and any complaints to, or investigations or hearings by, or on behalf of the Dental Board or registration body involving me whether or not there has been a final resolution and I consent to the disclosure of such information to MDA National Insurance or its Corporate Authorised Representatives, reinsurers or advisers, as appropriate.
6. I authorise and request any current or former insurer or indemnity provider to release all information requested by MDA National Insurance regarding all requests for indemnity or assistance including details of claims, complaints, investigations or inquiries involving me, whether or not there has been a final resolution and I consent to the disclosure of such information to MDA National Insurance and any of its reinsurers or advisers, as appropriate.
7. I consent to MDA National Insurance and any companies, firms or individuals who assist in providing services including reinsurers, Corporate Authorised Representatives, solicitors and barristers, holding and using the information I provide and any information provided about me or my practice by a registration body or current or former insurer or indemnity provider, in accordance with the MDA National Group Privacy Policy.

Please Sign and Date Here

Signed

Date / /

## Important Notice

To have a thorough understanding of the cover provided under your policy please read the following information in conjunction with the current *Dental Indemnity Policy Important Information and Policy Wording*, and any *Supplementary Important Information and Endorsement to Policy Wording*.

### Your duty of disclosure

Before you enter into an insurance contract, you have a duty, under the *Insurance Contracts Act 1984* (Cth) 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 something

If you do not tell us anything you are required to, we may cancel your contract or reduce the amount we will pay 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.

### Claims made cover

The Dental Indemnity Policy is a claims made contract of insurance. This means that the policy responds to matters that have occurred on or after the retroactive date and that you first become aware of and notify us in writing during the period of insurance.

### Privacy

Please note that any information you provide will be held and used by us and any companies, firms or individuals who assist us in providing services (including but not limited to reinsurers, medical specialists, solicitors and barristers) in accordance with the MDA National Group Privacy Policy.

### Requirement to notify us

You must notify us in writing as soon as practicable of any material alteration of the risk during the period of insurance including any material change in the nature of the professional services provided by you. You must also notify us as soon as practicable after you become aware of:

- (a) any claim, investigation or inquiry; or
- (b) any circumstance that might lead to a claim against you or to an investigation or inquiry involving you; or
- (c) any other matter which might give rise to a claim for indemnity under this policy.

### Rights under section 40(3) of the Insurance Contracts Act

If you have a policy with us and you notify us in writing of circumstances which may give rise to a claim during your period of cover, the fact that you do not give us written notice of a claim relating to those circumstances before your policy has expired will not, of itself, relieve us of liability in relation to the claim. However, you must notify us of a claim, investigation or inquiry as soon as you become aware of it.

### Payments

All monies received will be paid into an Australian bank account and held in trust on your behalf until we agree to accept your Insurance renewal. MDA National Insurance is entitled to the interest earned on this bank account. Your Membership subscription is collected on behalf of DPL Australia and will be allocated accordingly.





# Practice Category Guide

This Practice Category Guide is effective 1 July 2016.

It is to be read in conjunction with the current Dental Indemnity Policy Important Information and Policy Wording document and any Supplementary Important Information and Endorsement to Policy Wording issued by MDA National Insurance Pty Ltd ABN 56 058 271 417 AFS Licence No. 238073, and is applicable to direct and prospective Members of the Australian Dental Association (WA Branch) Inc (ADA WA).

For the calculation of private practice hours, you must include your total involvement in dentistry including clinical and non clinical work.

**Please be aware that you are required to have the appropriate recognised training and qualifications for the Dental services you provide and to ensure that you comply with Guidelines for Scope of Practice issued by the Dental Board of Australia.**

If you require any further information about practice categories, please contact ADA WA on 08 9211 5678.

Practice description	Category code	Category description
<b>Dentists and Specialists</b>		
<b>Students</b>	DST	<ul style="list-style-type: none"> <li>For dentistry students enrolled in, but not yet graduated from, a course of study approved by the Dental Board of Australia for the purpose of becoming a qualified registered dentist</li> </ul>
<b>Final Year Students /Dental Graduates</b>	FYS/GDY	<ul style="list-style-type: none"> <li>For final year dentistry students in their six months prior to graduation and for a new dental graduate</li> </ul>
	YD1	<ul style="list-style-type: none"> <li>For Australian graduates in their first full year after graduation</li> </ul>
	YGO	<ul style="list-style-type: none"> <li>For overseas graduates in their first full year after graduation</li> </ul>
	YD2	<ul style="list-style-type: none"> <li>For those in their second full year after graduation</li> </ul>
	YD3	<ul style="list-style-type: none"> <li>For those in their third full year after graduation</li> </ul>
<b>Part time</b>	SLA	<ul style="list-style-type: none"> <li>For those completing not more than four hours per week on average or up to a maximum of 200 hours during the financial year</li> </ul>
	SR1	<ul style="list-style-type: none"> <li>For those completing not more than 16 hours per week on average or up to a maximum of 770 hours during the financial year</li> </ul>
<b>Full time</b>	YD4	<ul style="list-style-type: none"> <li>For those in their fourth year or subsequent years after graduation</li> </ul>
<b>Surgical procedures</b>	YDX	<ul style="list-style-type: none"> <li>For any dentists or specialists where the total time spent on:               <ol style="list-style-type: none"> <li>the surgical placement of implants and/or the surgical removal of third molars occupies in total more than 10hrs per week on average (500 hours in total during the financial year); or</li> <li>the surgical placement of implants and/or the surgical removal of third molars occupies more than 50% of the total clinical time; or</li> <li>any sinus lift or bone augmentation procedures involving the maxillary sinus and/or nasal floor are carried out*</li> </ol> </li> </ul> <p><i>* NOTE - Carrying out any bone harvesting from outside the mandible is not included. If you are harvesting bone from outside the mouth, you need to be qualified and registered as an Oral and Maxillofacial surgeon and the RMA, OMX or OMZ categories may be appropriate. The surgical placement of implants and/or the surgical removal of third molars occupies more than 50% of the total clinical time.</i></p>

Practice description	Category code	Category description
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**Dentists and Specialists (continued)**

<b>Employer indemnified</b>	E1S	<ul style="list-style-type: none"> <li>For those who do not undertake any private practice and have an entitlement to indemnity from their employer for civil liability claims arising from their practice with their employer but require ongoing cover for their past private practice which is not subject to employer indemnity</li> </ul>
	E2S	<ul style="list-style-type: none"> <li>For those who have an entitlement to indemnity from their employer but who also do a small amount of private work which is not subject to employer indemnity</li> </ul> <p><i>This category covers private practice up to 16 hours per week on average or up to a maximum of 770 hours during the insurance year.</i></p>
<b>Voluntary Gratuitous Services</b>	VGS	<ul style="list-style-type: none"> <li>For those who have ceased all practice except for undertaking voluntary overseas Gratuitous Services</li> </ul>
<b>Absence from practice</b>	YDM	<ul style="list-style-type: none"> <li>For those who have ceased practice for greater than three months due to maternity leave</li> </ul>
	YLA	<ul style="list-style-type: none"> <li>For those who have ceased practice for greater than three months due to reasons other than maternity leave</li> </ul>

**Oral and Maxillofacial surgery**

<b>Part time</b>	RMA	<ul style="list-style-type: none"> <li>For those who are completing not more than 20 hours per week on average or up to a maximum of 1,000 hours during the financial year and are a Member of ANZAOMS</li> </ul>
<b>Full time</b>	OMX	<ul style="list-style-type: none"> <li>For those who are a Member of ANZAOMS</li> </ul>
	OMZ	<ul style="list-style-type: none"> <li>For those who are NOT a Member of ANZAOMS</li> </ul> <p><i>These categories allow unlimited private practice.</i></p>

**Notes**

**Adverse Risk**  
 There are a number of other categories for those who present a significantly higher risk to the insurer than their colleagues.