Application for Dental Membership South Africa

Please complete all sections of the form and return to Dental Protection Ltd, c/o SADA, Private Bag 1, Houghton 2041, South Africa. Subscriptions are payable for the period January to December. The fees for new members will be determined on a pro-rata basis for the remainder of the year. Existing members must renew their membership before the end of March annually to avoid cancellation of benefits.

Personal details

Title

First name/s

Surname/ Family name

Former name (if any)

Date of birth . .

Sex M ☐ F ☐

Nationality

Degrees and Diplomas

Dental School

Month and year of graduation

Address for correspondence

Postcode

E-mail

Telephone (Daytime)

Telephone (Evening)

Mobile no

Country of practice

Specialty (if any)

HPCSA registration no.

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

Will all your dental practice be carried out in South Africa? ☐ Yes ☐ No

If no, please give full details in the space below. If necessary please continue on a separate sheet.

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

Please note that signing the declaration on page 4 indicates acceptance of the requirements below:

Members undertake to keep DPL via SADA informed of their current address and any changes in their professional circumstances. Members should understand that neither MPS or DPL are insurance companies. The benefits of MPS membership are granted at the discretion of Council.

MPS Office use only

Date received:

Approved by:

Date approved:

Processed:

Start date:

Joining reason:

Grade:

Status:

Specialty:

DP:

Access number:

Membership number:

Notes:

! In this section you must include details of any matter where you have been named or involved. Please include any pending, unresolved or concluded issues, even those already reported to Dental Protection Ltd.

Previous Indemnity/Insurance

1. Have you belonged to a protection body or had malpractice insurance before (including previous membership with MPS)?

☐ YES (Please answer all questions below)
☐ NO (Please answer questions 3 to 10)

2. Please give the name of the organisation(s) and the dates during which you were a member or policy holder. If you were previously a member of MPS, please give your membership number and your name at the time (if it has changed).

Organisation	From	To	MPS No.	Name	Other membership or policy no

3. Have there been any gaps in your professional indemnity/insurance since the date of your graduation?

☐ YES (Please give a summary and reasons for any gaps on a separate sheet)
☐ NO

4. Have you ever been refused membership (including renewal) of a protection body (refused professional insurance) or been offered limited or conditional membership (terms) including higher subscriptions/premiums?

☐ YES (Please give full details on a separate sheet)
☐ NO

5. Have you ever been the subject of any complaint arising out of your professional practice? (If in doubt please indicate YES)

☐ YES (Please give a summary on a separate sheet)
☐ NO

6. 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 a summary on a separate sheet)
☐ NO

7. Have you ever been the subject of a disciplinary inquiry by your employer or had clinical rights refused/withdrawn/made conditional? (If in doubt please indicate YES)

☐ YES (Please give full details on a separate sheet)
☐ NO

8. Have you ever been subject to any complaint, inquiry or investigation or hearing by the HPCSA or any other registration body or had conditions imposed on your practice or been suspended or erased from any dental register? (If in doubt please indicate YES)

☐ YES (Please give full details on a separate sheet)
☐ NO

9. Have you ever been charged, cautioned or otherwise investigated by the police in respect of any criminal allegation?

☐ YES (Please give a summary on a separate sheet and return with copies of any HPCSA correspondence)
☐ NO

10. Do you know of any other issue of which Dental Protection might reasonably wish to be aware, when considering your application for membership? (If in doubt please tick YES and provide details)

☐ YES (Please give full details on a separate sheet)
☐ NO

Section A
Practice Details

A1. Please tick the box/es below which best describes your position:

☐ Dental Practitioner
☐ Non-clinical practice with hospital indemnity
☐ Non-clinical practice with employer indemnity
☐ Dental Therapist
☐ Oral Hygienist

Please contact the SADA office to enquire about the subscription fee payable.

Declaration

I wish to apply for membership of the Medical Protection Society subject to MPS 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 permit MPS to seek information regarding past and current matters from other professional protection bodies, insurance companies or employers with whom I have had professional indemnity arrangements.

I consent to MPS processing information about me. (Please see data protection information below).

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, income and/or sessions could result in the suspension of the benefits of membership and/or the termination of your membership.

Signature

Date

Data Protection Information

We will process the information you provide on our systems for administration of your membership, claims, 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 communications. 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 e-mail please tick this box. ☐

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

Where did you learn about Dental Protection?

- ☐ At dental school
- ☐ Personal recommendation
- ☐ Mailing from Dental Protection
- ☐ Other, please specify ____________________
- ☐ Press advertising
- ☐ SADA
- ☐ A Lecture/Presentation

Dental Protection

Contacting us:

Members can contact us locally via:

South African Dental Association
Private Bag 1
Houghton 2041
South Africa
Fax +27 (0)11 484 0660 or 086 683 0392
Tel: +27 (0)11 484 5288
Share call: 086 011 0725

United Kingdom offices

Dental Protection Limited
33 Cavendish Square
W1G 0PS
London
UK
Fax: +44 (0)20 7399 1401
Tel: +44 (0)7399 1400

Dental Protection Limited
Granary Wharf House
LS11 5PY
Leeds
UK
Fax: +44 (0)113 241 0601
Tel: +44 (0)113 243 6436

Membership and Advisory Services through the co-operation of SADA

A constituent of the South African Dental Association

The South African Dental Association (Incorporated Association Not for Gain)
Private Bag 1, Houghton 2041,
Tel+27(0) 11 484 5288 Share Call: 086 011 0725 Fax 086 683 0392
Email: dplmembership@sada.co.za

Dental Protection is a division of the Medical Protection Society Limited. Registered in England Number 36142.

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PAYMENT OPTIONS

A. ☐ CREDIT CARD   B. ☐ CHEQUE   C. ☐ DIRECT PAYMENT   D. ☐ DEBIT ORDER

A. CREDIT CARD (Please tick card type to be debited)

CARD (tick one box only)   MASTERCARD ☐   VISA ☐

CARD HOLDERS NAME

CREDIT CARD NO.

EXPIRY DATE — CVC

Our Membership Department will contact you to verify your CVC number. Please ensure your contact is filled in above.

CARDHOLDERS SIGNATURE

B. CHEQUE Cheques must be made payable to: The South African Dental Association (Not SADA)

I enclose my cheque in the sum of R

C. DIRECT PAYMENT INTO SADA ACCOUNT – ELECTRONICALLY OR BY DIRECT DEPOSIT

If you prefer, you can make your payment by electronic transfer at any ABSA Bank countrywide (for direct deposit using the deposit slip below). Please use your SADA Membership Number as a Reference Number.

D. FOR EASE OF PAYMENT THE FOLLOWING DEBIT ORDER INSTRUCTION MAY BE COMPLETED

The details of my/our bank are as follows:

BANK:

BRANCH NAME & TOWN:

BRANCH NO.   ACCOUNT NO.

TYPE OF ACCOUNT: CURRENT ☐   SAVINGS ☐   TRANSMISSION ☐   OTHER ☐

I hereby authorise the South African Dental Association to electronically collect a single payment not exceeding the amount of R ____________ via the ACB system using the information provided, and details of this will appear on my bank statement. I also irrevocably authorise the South African Dental Association to reverse any erroneous transaction and/or to rectify any electronnic transfer of funds error without prior notice. I agree to pay any changes related to unpaid returned items.

SIGNATURE   DATE D D M M Y Y Y Y

ABSA Bank Limited/Beperk. Reg No 1986/004794/06

DEPOSIT SLIP

Date: __________

Acc. No. 1 0 0 0 0 2 1 4 2 0

Credit: The South African Dental

The Bank shall not be held responsible for errors resulting from incorrect information furnished by the Customer or on his behalf. Furthermore, the Bank does not accept responsibility for ensuring that the Customer has lawful title to instruments handed in for collection.

Teller Stamp

Drawers name	Bank	Branch name/Clearing code	R	c

Details of Depositer

Signature __________ Tel (   ) __________

Total R

Please use the SADA Membership Number as a deposit reference

Dep reference

Payment instructions
Please do not remove.

Dental
Protection