

# NZCCP – NEW ZEALAND

## Scheme of co-operation



Please complete **all** parts of this form and return to: Caroline Greig, NZCCP, PO Box 24088, Wellington 6142.  
For enquiries please telephone: 04 801 6088 or email: office@nzccp.co.nz.

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
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Surname		Telephone (Day)	Telephone (Evening)
Title		Telephone (Mobile)	Fax no.
Forename(s)		Email address: (Please see declaration on page 3)	
Maiden or previous name (if any)		Degrees and diplomas	
Date of birth	Gender (Please tick)	Medical school	
D D M M Y Y Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	Month and year of graduation	
Nationality		M M Y Y Y Y	
Country of permanent residence		Annual Practising Certificate registration no. and date of registration Your application may be delayed if this is not provided	
Country of practice		Any specialist registration	
Address for correspondence		Main specialty	
Postcode (zip code or postal area)		Date of specialist registration	
		D D M M Y Y Y Y	

### Important information – please read

- 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.
- 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.
- 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.
- 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.
- As MPS provides occurrence based membership, we would not assist with any matter arising from an incident pre-dating your MPS membership.
- 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.

**MPS 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?	<input type="checkbox"/> Yes (Please answer all questions below.)
	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> No
5. Have you ever been refused professional indemnity/insurance, including refusal to renew or been offered limited or conditional terms?	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> No
6. Have you ever been the subject of any complaint arising out of your professional practice? (If in doubt please indicate YES.)	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> No
10. Have you ever been cautioned by the police in respect of, or convicted of, any criminal allegation (including road traffic offences)?	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes (Please give dates and details below)*
	<input type="checkbox"/> No

# NZCCP membership

Primary location of practice		
<input type="checkbox"/> Child & Family	<input type="checkbox"/> Neuropsychology	<input type="checkbox"/> PHO
<input type="checkbox"/> Forensic	<input type="checkbox"/> DHB	<input type="checkbox"/> Other (Please specify)
<input type="checkbox"/> ACC Sensitive Claims	<input type="checkbox"/> Corrections	
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> University	
<input type="checkbox"/> Alcohol & Drug	<input type="checkbox"/> Private Practice	

## Payment instruction

I wish to pay my subscription (including 12.5% GST) by the indicated payment method below

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 shall not be affected.

<input type="checkbox"/> <b>Cheque</b> Cheques should be made payable to <b>NZCCP</b> and returned to <b>Caroline Greig, NZCCP, PO Box 24088, Wellington 6142.</b>
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Signature
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Please charge: <b>NZ\$</b>
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Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
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## Declaration

### PLEASE PROVIDE A COPY OF YOUR ANNUAL PRACTISING CERTIFICATE (APC)

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 above.

#### 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

Signature
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Date

<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
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### 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.

# MPS – New Zealand

## Contact information

c/o NZCCP  
PO Box 24088,  
Wellington 6142.

Telephone 04 801 6088

Email [office@nzccp.co.nz](mailto:office@nzccp.co.nz)

Website [www.medicalprotection.org/newzealand](http://www.medicalprotection.org/newzealand)

### 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)

### 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](http://www.medicalprotection.org)  
[international@mps.org.uk](mailto:international@mps.org.uk)

The Medical Protection Society Limited  
A company limited by guarantee  
Registered in England No. 36142 at  
33 Cavendish Square, London W1G 0PS, UK

MPS is not an insurance company.  
All the benefits of membership of MPS are discretionary  
as set out in the Memorandum and Articles of Association.