

MEMBERSHIP APPLICATION SINGAPORE

6220 2588 | membership@sda.org.sg | dentalprotection.org

Please complete in BLOCK CAPITALS, sign and return to: **Singapore Dental Association, 2 College Road, Singapore 169850**. For enquiries telephone 6220 2588 or fax 6224 7967. Email: membership@sda.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:

D	D	M	M	Y	Y	Y	Y
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Section A – Personal details

Title	_____
First name	_____
Surname	_____
Former name if any	_____
Date of birth (DD/MM/YYYY)	_____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	_____
Authority registration number	_____
Degrees and diplomas	_____
Dental school and country	_____
Month and year of graduation (MM/YYYY)	_____
Country of practice	_____

Address for correspondence	_____ _____ _____ _____
Postcode (zip or postal area)	_____
Daytime telephone	_____
Evening telephone	_____
Mobile number	_____
Fax number	_____
Email address	_____

IMPORTANT! – Please read the following

1. 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 seek advice or assistance from Dental Protection.
2. 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.
3. If you have had professional indemnity or insurance (other than from Dental Protection) for any practice outside your stated country of practice you must obtain your case history to submit with this application.
4. If you have had previous indemnity or insurance we may approach your previous indemnity or insurance organisation for your claims history. This process will take a minimum of 15 working days.
5. We will 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 dental membership of MPS.

Please note that signing the declaration on page 5 indicates acceptance of the following requirements:

Members must keep Dental Protection informed of their current address and any changes in their professional circumstances. Failure to notify us of any change of address, private practice income and scope of practice could result in the withdrawal of the benefits of membership and/or the termination of your membership. 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.

Section B – Previous History  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 Dental Protection. Failure to disclose full and accurate details about your previous history may delay your application. If necessary please continue your answers on a separate sheet.

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

Section C – Practice details (If necessary please provide FULL details on additional sheets)

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?

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

1. Please tick the box/es below which best describes your position?

- | | |
|--|---|
| <input type="checkbox"/> Dentist (first year following graduation) | <input type="checkbox"/> Non-clinical Dentist (please enclose current job description) |
| <input type="checkbox"/> Dentist (second year following graduation) | <input type="checkbox"/> Employer Indemnified Dentist |
| <input type="checkbox"/> Dentist (third or subsequent year following graduation) | <input type="checkbox"/> Hygienist |
| <input type="checkbox"/> Division 1 Category I Dentist | <input type="checkbox"/> Therapist |
| <input type="checkbox"/> Division 2 Category II Dentist | <input type="checkbox"/> Specialist Practice, please specify specialty eg, orthodontics, oral and maxillofacial surgeon |

2. Are you a member of the Singapore Dental Association?

Yes No

Section D – Limited clinical activity (If you are claiming a concessionary rate, please complete as appropriate)

1. If you wish to apply for a reduced subscription rate because your clinical activity is limited, please tick one of the boxes below.

- My current clinical activity is no more than **10** hours/week (500 hours/year)
- My current clinical activity is no more than **20** hours/week (1,000 hours/year)

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

1. Personal recommendation
2. Competitive subscription rates
3. Dental Protection membership coordinator, please provide their initials:
4. Group arrangement
5. Dissatisfaction with previous organisation
6. Dental Protection event / conference
7. Other (please provide details in the space provided)

IMPORTANT! – Please read the following and sign below**Data/Personal Information**

At times we will ask you to provide us with data and personal information including when you apply for membership, your subscription is renewed, your scope of practice changes and if you seek and we provide assistance to you. In applying for membership and by continuing as a member you agree that (i) we may hold and process your personal data including sensitive personal data (as defined in the United Kingdom's Data Protection Act 1998 (the Act)) which you provide to us or which we fairly obtain from another source for the purposes of processing your membership renewal, the administration and provision of membership services, providing you with the benefits of membership (including, but not limited to, advice, assistance and indemnity), underwriting, risk assessment, marketing, education, research and audit during your membership and for a reasonable period after your membership terminates or an application for membership renewal is rejected by us or withdrawn by you and (ii) we may share such data with third parties who may also hold and process the data for the same purposes. Under the Act you have the right to ask us for a copy of any of your personal data which we hold, for which we make a nominal charge.

You also agree that (i) we may seek information relevant to any purpose for which you have agreed we may hold personal data from other professional defence organisations, insurance companies, employers or other third parties regarding your professional practice and career history and that they may release to us such information, (ii) your personal information or data may be transferred to, held and processed within the European Economic Area (EEA), which has a standard of protection of such information or data comparable to the protection under the Singapore Personal Data Protection Act 2012. A summary of the regulatory regime governing data protection in the EEA may be found at ico.org.uk/for-the-public, and (iii) if you provide us with an email address or telephone number it may be used by us and third parties to contact you for any of the purposes for which you have agreed to allow us or them to hold or process your personal data.

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

By signing and returning this form you 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 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 and/or the association 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 changes.

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. If you do not wish to receive such information, either via post or email, please tick this box.

Signature:

Date: DDMMYYYY (Please note must be current date)

Please remember to inform us promptly if your personal circumstances or scope of practice change.

Dental Protection – Singapore**Contact information**

c/o Singapore Dental Association,
2 College Road, Level 2
Alumni Medical Centre
Singapore 169850

T 6220 2588

F 6224 7967

membership@sda.org.sg

dentalprotection.org/singapore

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