Professional Indemnity Insurance
Proposal Form for Medical Practitioners

I. General Data

1. Name of proposer in full

2. Business address

3. a) At what medical school did the proposer graduate?

   b) Year of graduation

4. Where has the proposer practiced his profession since graduation?

In	from	to
In	from	to

5. Is the proposer duly licensed in accordance with law to practice at the address given under item 2?

   yes no

6. Member of association? yes no

II. Nature and volume of your present and foreseeable future activities

1. Is the proposer or assistant practicing as

a)	Physician	yes	no
b)	Surgeon	yes	no
c)	Cosmetic surgeon	yes	no
d)	Anaesthetist	yes	no
e)	Gynaecologist	yes	no
f)	Urologist	yes	no
g)	Orthopaedist	yes	no
h)	Radiologist	yes	no
i)	Dentist	yes	no
j)	Any other, not shown If so, please specify.	yes	no

2. Is the proposer, partner or assistant regularly involved in first-aid service?

yes no

3. Name(s) of partners

For each partner all questions listed above have to be answered individually.

4. Name(s) of qualified medical assistant(s)

5. Number of technicians employed _____

6. Number of nurses employed _____

7. Is the proposer under contract with or in the employment of any individual, firm or Corporration? yes no

If so, please give details.

8. Does the proposer own, wholly or in part, operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? yes no

Does he have any reserved beds there?
If so, please give details including number of reserved beds.

9. Does the proposer own or operate X-ray machines or laser? yes no

If so, please give number, type and whether they are used for diagnosis or treatment or both.

10. Number of patients per year _____

III. Previous insurance/previous claims

1. Has the proposer previously been insured? yes no

   If so, please specify:

	Name of Insurer	Policy Period	Limit of Indemnity
1			
2			
3			
4			
5			

2. Has a previous application been declined? yes no

   Has a previous insurance
   a) required increased premium? yes no
   b) required special restrictions? yes no
   c) been terminated/not been renewed by an insurer? yes no

   If so, please give detailed information.

3. Have any claims or suits for malpractice been made against the proposer or any of his partners, assistants, nurses or technicians during the past five years? yes no

   If so, please advise amount and background of each claim.

4. Is the proposer or any of his partners, assistants, nurses or technicians aware of any circumstances or incidents which may result in a claim?

   yes no

   If so, please give details.

IV. Indemnity required

1. Limit any one claim

2. Aggregate Limit

3. Deductible each and every claim to be borne by insured

V. Endorsements to basic cover

1.	Extended Claims Reporting Period	yes	no
2.	Loss of Documents If so, up to what amount?	yes	no

I/We declare that the statements and particulars in this proposal are true and that I/we have not misstated or suppressed any material facts. I/We agree that this proposal, together with any other information supplied by me/us, shall form the basis of any contract of insurance effected thereon.

Signing this proposal form does not bind the proposer or underwriter to complete this insurance.

Dated this day of 20

For and on behalf of _____
(insert name of firm)

Signature of partner or principal