**Professional**
**Indemnity Insurance**
**Proposal Form**
**Medical Malpractice**
**Practitioners**

| | | | |
|---|---|---|---|
| **I** | **General data** | | |
| | 1. Full name : | | |
| | 2. Business address | | |
| | 3. a) At what medical school did the proposer graduate? | | |
| | b) Year of graduation : | | |
| | c) Qualifications : | | |
| | 4. Where has the proposer practised his profession since graduation? | | |
| | In From to | | |
| | In From to | | |
| | 5. Is the proposer duly licensed in accordance with law to practise 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 practising 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<br><br>i) Dentist<br><br>j) Any other, not shown : Reconstructive Surgeon<br><br>**If so**, please specify. | Yes No<br><br>Yes No<br><br>Yes No |
| 2. | Is the proposer, partner or assistant regularly involved in first-aid service? | Yes No |
| 3. | Name(s) of partner(s)<br><br>For each partner all questions listed above have to 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 employ of any individual, firm or corporation?<br><br>**If so**, please give details | Yes No |
| 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?<br>Does he have any reserved beds there?<br><br>**If so**, please give details. | Yes No |
| 9. | Does the proposer own or operate X-ray machine or laser?<br><br>**If so**, please give number, type and whether they are used for diagnosis or treatment or both. | Yes No<br><br>Yes No |
| 10. | Number of patients per year | |

| | | | | |
|---|---|---|---|---|
| **III** | **Previous insurance / previous claims** | | | |
| 1. | Has the proposer previously been insured?<br><br>**If so**, please specify: | | | Yes No |
| | Name of insurer | Policy period | Limit of indemnity | |
| | 1.<br>2.<br>3.<br>4.<br>5. | | | |
| 2. | Has the 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?<br><br>**If so**, please advise amount and background of each claim. | | | Yes No |
| 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 or claims?<br><br>**If so**, please give details. | | | Yes No |
| **IV** | **Indemnity required** | | | |
| 1. | Limit of any one claim | | | |
| 2. | Limit in the annual aggregate | | | |
| 3. | Deductible each and every claim to be borne by insured. | | | |

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 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

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

Signature of partner or principal _____