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MIDDLESEA
A MEMBER OF THE MAPFRE GROUP

Professional Indemnity Insurance Proposal Form
Medical Malpractice / Practitioners

GUIDELINES TO COMPLETING THE PROPOSAL FORM

PLEASE READ THE FOLLOWING GUIDELINES BEFORE COMPLETING THIS PROPOSAL FORM. WHERE FURTHER INFORMATION OR CLARIFICATION IS REQUIRED PLEASE REFER TO OUR OFFICES OR TO YOUR INSURANCE BROKER OR INSURANCE SALESMAN.

IT IS IMPORTANT TO NOTE that this Proposal Form is for indemnification on a CLAIMS MADE BASIS. This Policy will only respond to "Claims" made against the Proposer and notified to Insurers during the period of insurance.

A. This proposal must be fully completed, signed and dated by the person (The Proposer) seeking the quotation for Medical Malpractice Insurance. Please answer every question fully and state "NIL " or "NONE" as applicable. Unless the Proposal is fully completed a final quotation cannot be given. The completion and signature of the Proposal does not bind the Proposer or Insurers to complete a Contract of Insurance.

B. It is the duty of the Proposer to disclose all material facts to Insurers. Where this is omitted, the Insurers may avoid their obligations under the Policy.

   A material fact is one that is likely to influence an Insurer's judgment and acceptance of your Proposal.

C. Please submit any additional information you feel may be of assistance to Insurers.

D. Upon acceptance of Insurers' terms and conditions and payment of the premium, all information provided by the Proposer together with these guidelines will be deemed to be incorporated in the contract between Insurers and the Proposer.

E. Copies of Proposal Forms should be retained for your own records.

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Medical Malpractice / Practitioners

I. General Data 1. Name of Proposer	
2. Business address	
3. Telephone Number	
4. I.D Card Number / Company Registration Number	
5. a) At what medical school did the Proposer graduate? b) Year of graduation	
6. Please state the degree obtained and give any details of any post graduate qualifications where applicable	
7. Where has the proposer practiced his profession since graduation? In _____ from _____ to _____ In _____ from _____ to _____	
8. Is the proposer duly licensed in accordance with law to practice at the address given under item 2?	Yes No
9. Please state your original number or registration and the date of registration.	
10. Member of association? If so, please give details.	Yes No

II. Nature and volume of your present and foreseeable future activities 1. In what branch or branches of medicine are you qualified and licensed to practice a) Anasthesiology b) Cardiology c) Dermatology d) Dentistry e) ENT Specialists f) General Practice g) General Surgery h) Geriatricians i) Gynaecology j) Haematology k) Internal Medicine l) Neurology m) Obstetrics n) Oncology o) Opthalmology p) Orthodontics q) Orthopaedics r) Paediatrics s) Pathology t) Plastic Surgery u) Psychiatry v) Radiology w) Urology x) 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 cooperation? 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? Does he have any reserved beds there? If so, please give details including number of reserved beds.	Yes No Yes No
9. Does the Proposer own or operate X-ray machines or laser? If so, please give number, type and whether they are used for diagnosis or treatment or both.	Yes No
10. Number of patients per year	
11. Please give full details of what patient records are kept and where and how they are stored	
12. Please state the fees earned for the previous two years and projected fees for this 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? b) required special restrictions? c) been terminated/not been renewed by an insurer?	 Yes No Yes No 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? If so, please advise amount and details 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? If so, please give details.	Yes No
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. Retroactive Cover If so, indicate number of years (maximum number of years – 5 years)	Yes No
2. Libel and Slander	Yes No
3. Loss of Documents	Yes No
4. Dishonesty of Employees	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

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

Signature of partner or principal _____