Proposal Form

Professional Indemnity - Hospitals

(The liability of the Company does not commence until this proposal has been accepted by the Company and the premium paid)

1. Information given herein will be treated in strict Confidence.
2. Put a (√) mark wherever applicable.
3. If space is not sufficient in any column, please give details on a separate sheet of paper.
4. Kindly answer all questions completely in order to help us to serve you better.

1.	Name of the Hospital/Clinic to be Insured
2.	Hospital / Clinic Address
3.	E mail id
4.	Telephone number(s)
5.	Name of Subsidiaries or controlled entities required to be Insured (if any)
6.	a) Medical Registration No. b) Year of Registration
7.	Applicant's organization information (Please tick) Partnership __ Private Co. __ Public Co. __ Others __
8.	Please list the activities performed/services being offered at the hospital/clinic a) General Practitioner /General Physician / Surgeon b) Pathologist / Radiologist c) Consulting Physician d) Anesthetist / Plastic Surgeon e) ……..

<table>
<tr><td rowspan="4">9.</td><td>a) Specify facilities such as dispensing facility, X-ray, radiation therapy, scanning, ECG, Sonography, MRI, operation theatre etc., available / operated by you or under your control.</td><td></td></tr>
<tr><td>b) Are these facilities being maintained through regular service contracts with the manufacturers/ specialized servicing Agencies?</td><td></td></tr>
<tr><td>c) If these facilities are operated by employees, please state their i) names ii) technical qualification iii) experience and iv) name of the facility operated (please use separate sheet)</td><td></td></tr>
<tr><td>d) Please indicate whether you wish to extend the policy to cover, out of the above list, personal who are not qualified to operate the facility mentioned against their names</td><td></td></tr>
<tr><td>10.</td><td colspan="2">Name, specialization and qualifications of doctors in full employment with you
<table>
<tr><th>Name of the Doctor/ Surgeon</th><th>Area of specialisation</th><th>Qualification</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
(you may attach a list if required)</td></tr>
<tr><td>11.</td><td colspan="2">Name, specialization and qualifications of visiting doctors
<table>
<tr><th>Name of the Doctor/Surgeon</th><th>Area of specialisation</th><th>Qualification</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
(You may attach a list if required)</td></tr>
<tr><td>12</td><td colspan="2">Number of full-time professionally qualified nursing staff and their names</td></tr>
<tr><td>13</td><td colspan="2">Number of other Technical and Non- Technical staff

1. Technical Staff
2. Non-Technical Staff</td></tr>
</table>

<table>
<tr><td>14</td><td>Please provide the name and position of each director/senior officer of the business entity:
<table>
<tr><th>Name</th><th>Position Held</th><th>Date of appointment</th><th>Details of professional association membership</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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</table>
(Attach a list if required)</td></tr>
<tr><td></td><td>Total amount of gross fees or annual income:

• Last 12 months K
Estimate for the next 12 months K
Total assets (consolidated) K</td></tr>
<tr><td></td><td>What arrangements do you have in place to conduct business or practice during the temporary absence of partners, principals or professionally qualified staff away on business, holidays, sick leave etc?</td></tr>
<tr><td>10.</td><td>State the average number of patients being attended per day</td></tr>
<tr><td>11.</td><td>Have any claims been made upon you or legal proceedings instituted or likely to be instituted against you by patients in respect of your treatment etc., If so, please give details.</td></tr>
<tr><td>12.</td><td>Have you been previously insured for the subject risk? If so, give full particulars</td></tr>
<tr><td>13</td><td>Has any Company
a) declined your proposal Yes/No
b) required an increased premium Yes/No
c) refused to renew your policy Yes/No
d) cancelled such a policy Yes/No</td></tr>
</table>

14.	Limit of Indemnity required Any one Accident Kina Any One year Kina
15.	Period of Insurance: From_____ to _____

I / We do hereby declare that the above statements and answers are true and what I / We have not withheld any information whatsoever regarding the proposal. I / We hereby declare that all statutory provisions relating to my/our business proposed for insurance are complied with. I / We agree that this proposal and declarations shall be the basis of the contract between me/us and Liberty Assurance Limited whose policy for the insurance proposed is acceptable to me/us. I / We under take to exercise all ordinary and reasonable precautions for safety of the property as if it were uninsured.

Date:

Place:

Signature of Proposer

IMPORTANT NOTE

1. *Specimen copy of the Policy Form and other terms applicable to risk is available, on request by the Proposer.*

2. *Please note that the above is for your general information only. For further details and specific information, please refer to the Policy whose terms and conditions, exceptions, clauses and warranties are applicable to this insurance.*

3. *The Policy holder shall keep a record of all information including copies of letters supplied to the insurers for the purpose of entering into the contract. A copy of the completed Proposal Form will be supplied to the Proposer on request after its completion*