Medical Malpractice (Hospitals) Proposal Form

General Data

1. Full name of proposing institution:
2. Business address
3. Date of Establishment
4. Is the proposer approved by a public authority? Please give name of the authority and date of approval.
5. Is the proposer a member of hospital association? Give name of the association and date of acceptance.
6. Is the proposer maintained in whole or in part by public or private funds or endowment? Please specify.

Nature and volume of your present and foreseeable future activities

1. Brief description of the proposer's activities (e.g. operation of a hospital, nursing home, sanatorium).
2. Estimated gross annual income

Approximate number of	in-patients	out-patients
General		
Surgical		
Gynaecological and obstetrical		
Paediatric		
Orthopaedic		
Dental		
Psychiatric		
Any other class		

Please specify number of patients per nationality

Number of employed doctors (including doctors in clinics) in each of the following classification

Surgeons Cosmetic surgeons Anaesthetists Gynaecologists Urologists

Internal specialists Radiologistis Dentists Ophthalmalogists orthopaedists

Interns(licensed / unlicensed) physicians others (specify) visiting doctors

Number of other employees:

Pharmacists Radiologists Lab. Technicians Other Medical assts.

Graduate Nurses other nurses other employees

Number of Beds:

Does the proposer own or operate X-ray machines, lasers, ultrasound machines or similar equipment? If so, please give number and type of machines and specify whether they are used for diagnosis or treatment or both.

Does the proposer use radioactive materials? If so, please specify machinery and/or material used.

Does the proposer operate a blood bank? If so, please advise percentage of use for own purpose and for supply to other parties.

Previous Insurance / Previous Claims

Has the proposer previously been insured? If so, please specify:

Name of Insurer Policy period Limit of Indemnity Deductible

Has a previous application been declined?

Has a previous insurance required a higher premium or special restrictions?

Has a previous insurance been terminated/not been renewed by an Insurer? If so, please give details.

Have any claim or suits for malpractice been made during the past 5 years against the proposer? If so, please advise amount and back ground of each claim on separate sheet.

Is the proposer aware of any circumstances or incidents which may result in a claim or claims against him? If so, please give details.

Indemnity Period and extensions:

Limit any one claim:
Limit in the annual aggregate
Deductible each and every claim to be borne by the Insured
Third Party Liability
Products Liability
Other Extensions (specify)
Other Extensions (specify)

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 Company to complete this insurance.

Date:

For and on behalf of the proposer(s)

Signature of the partner or principal