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PROPOSAL FORM FOR PROFESSIONAL INDEMNITY - MEDICAL MALPRACTICE LIABILITY PRACTITIONERS - (Part 2)

1. a) At what Medical School did you obtain your Qualifications ?
   b) In what year did you qualify ?
   c) What degree did you obtain ?

2. State whether you practice as a :(Please tick appropriate Speciality)

☐ Abdominal Surgeon	☐ Orthopaedic Surgeon	☐ Radiologist /Roentgenologist
☐ Cardiologist	☐ Otorhinolaryngologist	☐ Thoracic Surgeon
☐ Cardio-Vascular Surgeon	☐ Pathologist	☐ Urologist
☐ General Surgeon	☐ Physician	☐ .....
☐ Neuro-Surgeon	☐ Physician and non-specialist Surgeon	☐ .....
☐ Obstetrician & Gynaecologist	☐ Plastic Surgeon	☐ .....
☐ Oncologist	☐ Proctologist	☐ .....
☐ Opthamologic Surgeon	☐ Psychiatrist	☐ .....

3. a) Name of Partners

(For insurance purposes each Partner is required to complete a Proposal Form)

b) If you are the employee of a practice :

(i) What is its title ?

(ii) Name all other employees of the corporation

1 :	7 :
2 :	8 :
3 :	9: :
4 :	10:
5 :	11:
6 :	12:

c) If you are not the employee of a practice, please :

(i) Name all qualified Assistants (each must complete a proposal form).

(ii) Names of Nurse Anaesthetists (with qualifications).

(iii) Names of Nurse Anaesthetists (with qualifications).

(iv) Names of Other Nurses (with qualifications).

Name	*Career Type*	*Qualifications*

d) Do you require any of your employees to be named Insured's ? ☐ Yes ☐ No

If YES; please give details.

4. Where have you practised your profession since graduation and what year(s) ?

Practised Profession	*Year (s)*

5. Are you duly licensed in accordance with law to practice at the address(es) specified in Section 2 of Part 1 *(Professional Indemnity General Information form)* ☐ Yes ☐ No

6. Of what Professional Associations or Societies are you a member in good standing ?

7. Do you advertise your business or profession :
a) other than as permitted by your National or Local Professional Associationor Society ? ☐ Yes ☐ No

b) other than by an entry in the yellow pages giving only your address and telephone number ? If YES; please give details. ☐ Yes ☐ No

8. State approximate division of your work and indicate if you require coverage for the following :

No.	*Work*	*Cover Required ?* (*Indicate by "YES"*)	*Percentage of Total Work Performed*
1	The prescription or fitting of Contact Lenses		
2	Hypnosis		
3	The treatment of mental illness, drug addiction or alcoholism		
4	Diagnostic X-Ray procedures (other than plain X-ray)		
4-a	Angiographic procedures and Cardiac Catheterisation		
b	Administration of spinal, caudal, epidural or general anaesthesia		
5	Plastic Surgery (other than minor skin grafts)		
5- a	Traumatic		
b	Cosmetic		
6	Major Surgery, which shall be defined as :		
6 -a	Orthopaedic Surgery (other than orthopaedic operations on smaller joints)		
b	Neuro-Surgery		
c	Amputation of Limbs		
d	Plating, pinning open reduction of fractures		
e	Procedures involving entry surgically or otherwise into the spine, thorax or skull		
f	Procedures involving entry surgically or otherwise in the abdomen (other than procedures concerned with normal delivery which may include episiotomy and application of low forceps).		
g	Mastectomy.		
h	Resection of facila bones and tissues		
i	Operations on the organs of the neck (other than biopsy excision of lymph nodes)		
j	Reconstructive vascular surgery and thromboembolectomy of the larger arteries and veins.		
k	Ophthalmic Surgery		
l	Mastoidectomy		
m	Operations on the inner ear		
n	Oesophagoscopy		
o	Exchange Transfusions		
7	Intermediate Surgery which shall be defined as :		
a	Tonsillectomy		
b	Adenoidectomy		
c	Closed reduction of fractures		
d	Surgical or injection treatment of varicose veins		
e	Orthopaedic operations on the smaller joints		
f	Amputation of digits		
g	Dilation and curettage.		
h	Culdoscopy		
i	Cytoscopy		
j	Gastroscopy		
k	Sigmoidoscopy		

l	Bronchoscopy		
k	Biopsy excision of lymph nodes		
m	Circumcision		
8	General Practice which in no circumstances includes any of the procedures in (7) above.		
9	Any other procedure (please describe).		

N.B. Coverage is afforded only in respect of the procedures listed in (7) above for which a specific premium has been paid and in addition for General Practice. If coverage is required for any other procedures, such procedures must be specifically declared.

11. Have you or any of your Partners, Assistants, Technicians or Nurses any physical, physiological, emotional, pathologic or psychiatric disability ? ☐ Yes ☐ No

    If YES; please give details.

12. Are you engaged in any additional medical activities for which you receive payment ? ☐ Yes ☐ No

    If YES; please give details.

13. Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered ? ☐ Yes ☐ No

    If YES; please give details.

14. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offences ? ☐ Yes ☐ No

    If YES; please give details

15. Have you ever been the subject of disciplinary proceedings or reprimand by an administrative body or a professional association ? ☐ Yes ☐ No

If YES; please give details

16. Please state amount of insurance required :

Maximum : inclusive of costs andexpenses

any one patient.

17. FEE INCOME

(This question must be completed accurately as the figures are used for rating purposes)

a) Please give gross fees received during the past five years :

Year	*Gross Fees*

b) Please give the estimated fees for the coming 12 months. :

DECLARATION :

I/We hereby declare that the above statements and particulars contained in Parts 1 & 2 of this Proposal are true and complete, that at the present time, other than as stated, I/We have no reason to anticipate any claim under the insurance now being requested. I/We agree that this Proposal and declaration shall be the basis of the contract between me/us and the Insurers.

Proposer's Signature : _____ Date : _____

NB :

IF THIS PROPOSAL IS BEING COMPLETED FOR THE RENEWAL OF AN EXISTING POLICY, PLEASE REMEMBER COVER LAPSES AUTOMATICALLY AT MIDNIGHT ON THE LAST DAY OF YOUR EXPIRING POLICY, UNLESS A WRITTEN EXTENSION NOT LONGER THAN 10 DAYS IS REQUESTED AND HAS BEEN GRANTED FROM INSURERS, OR RENEWAL TERMS HAVE BEEN ACCEPTED.