PROFESSIONAL INDEMNITY INSURANCE PROPOSAL FORM FOR HOSPITAL MALPRACTICE

I General Date

1. Name of Institution: (herein referred to as "the proposer")

2. Business Address:

3. Date of establishment:

4. Is the proposer

   a) approved by a public authority? Yes [ ] No [ ]
   Name of the authority and date of approval

   b) a member of a hospital association? Yes [ ] No [ ]
   Name of the association and date of acceptance

5. Is the proposer maintained in whole or in part by public or private funds or endowment? Yes [ ] No [ ]

   Please specify.

II. Nature and volume of your present and foreseeable future activities

1. Brief description of the proposer's activities
   (e.g. operations of a hospital, nursing home, sanatorium)

2. Estimated gross annual income
   (please indicate currency)

3. Number of patients per year Numbers

   a) In-patients ……
   b) Out-patients……

4. Approximate division of patients between

   a) General
   b) Surgical
   c) Gynaecological and obstetrical
   d) Paediatric
   e) Orthopaedic
   f) Dental
   g) Psychiatric
   h) Any others classes

5. Number of employed doctors (including doctors in clinics)
In each of the following classifications Numbers

a) Surgeons……..... b)
Cosmetic Surgeons……. c)
Anesthetists……..... d)
Gynecologists…… e)
Internal specialists……... f)
Urologists…… g)
Orthopedists.....……. h)
Radiologists……..……. i)
Ophthalmologists……. j)
Dentists……
k) Physicians…….
l) Interns (licensed and unlicensed)……
m) Others (please specify)……...

6. Medical assistants (pharmacists, laboratory technicians, etc.) Numbers

7. Number of nurses

a) Graduates…….…
b) Undergraduates or students……

8. Number of beds (including for maternity cases)

9. Does the proposer own or operate X-ray machines, lasers, Ultrasound machines or similar equipment? Yes [ ] No [ ]

If so, please specify and give number of machines, type and whether they are used for diagnosis or treatment or both

10. Does the proposer use radioactive materials? Yes [ ] No [ ]
If so, please specify machinery and/or materials used.

11. Does the proposer operate a blood bank? Yes [ ] No [ ]
If so, please advise percentage of use
a) For own purpose
b) For supply to other parties

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.		

2. Has a 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 during the past five years against the proposer? Yes [ ] No [ ]

If so, please advise amount and background of each claim.

4. Is the proposer aware of any circumstances or incidents which may result in a claim or claims against him? Yes [ ] No [ ]

If so, please give details

IV Indemnity Required

1. Limit 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 contract of insurance effected thereon.

Signing this proposal form does not bind the proposer or underwriter to complete this insurance.

Date: …….

Nam of Hospital/ Clinic…….

Signature of partner or principal