THE NEW INDIA ASSURANCE CO. LTD.
P.O. BOX 2907, Ruwi, PC:112
Sultanate of Oman

……INSURANCE CO. LTD

PROPOSAL FORM FOR DOCTORS' AND MEDICAL PRACTITIONERS'.

PROFESSIONAL IDEMNITY

This proposal must be signed. All questions must be answered. The completion and signature of this proposal does not bind the proposer or Insurer to compete a contract of Insurance

If there is insufficient space to answer question, please use additional sheets and attach it to this form.

The Company does not assume any liabilities until the Proposal has been accepted and premium paid.

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1) Name of Proposer

2) a) Residential address
b) Clinic address

3) a) Professional Qualifications and the year of such qualifications
b) In which branch of medicines viz. Allopathy/Homeopathy/Ayurvedic/Any other – please specify.

4) a) Medical Registration No.
b) Year of Registration
c) How long have you been practicing

5) Are you a member of any Medical Association/ Council?
If so, please state Name and Address of such Association/ Council with Membership No.

6) Are you a

a) General Practioner/ General Physician
b) Pathologist/Radiologist
c) Consulting Physician
d) Anesthetist/ Plastic Surgeon

Note: If Specialist, please specify your line of specialization.

7 a) Specify facilities such as dispensing facility, X-ray radiation therapy, scanning ECG, Sonography, MRI etc. available/operated by you or under your control.

b) Are these facilities being maintained through regular service contracts with the manufacturers/ specialized serviced Agencies?

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)

d) Please indicate whether you wish to extend the policy to cover, out of the above list, personnel who are not qualified to operate the facility mentioned against their names.

8) Specify No. of employees, their job specifications, their experience and nature of your supervision.

9) a) i) Are you attached to/or attending as a visiting physician/surgeon in any Hospital/Nursing Home/Clinics etc,. If yes, please give details:
b) Are they covered under a Medical Establishment-Errors & Omissions policy?

10) State the average number of patients you are attending per day.

11) 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.

12) Have you been previously insured for the subject risk? If so, give full particulars.

13) Has any Company
(a) declined your proposal
(b) required an increased premium
(c) refused to renew your policy
(d) cancelled such a policy.

14) Limit of Indemnity required
For Any one act -RO
Any one year Limit - RO

15) Period of Insurance - From To

I/We do herby 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 compiled with. I/We agree that this proposal and declarations shall be the basis of the contract between me/us and ……..Co. Ltd, whose policy for the insurance proposed is acceptable to me/us. I/We undertake to exercise all ordinary and reasonable precautions for safety of the property as if it were uninsured.

Date:
Place:

SIGNATURE OF PROPOSER

Development Officer's Report:

The Proposer is known to me/my Agent for _____ years and I recommend acceptance of this proposal.

Date:
Place:

SIGNATURE OF DEVELOPMENT OFFICER
NAME AND CODE NO. OF DEVELOPMENT OFFICER

Note

1) The liability of the Company does not commence until the proposal has been accepted by the Company and premium paid.
2) Premium will be quoted on application.