الوثيقة المعتمدة لوساطة التأمين
Authorized Policy Insurance Brokers
The Pursued Safety | الأمان المنشود

MEDICAL MALPRACTICE INSURANCE FORM

1. a. Proposer's Full Name: _____
   Postal Address: _____
   b. Identity or C.R. Number: _____
   c. Tel No.: _____ Fax No.: _____ Mobile: _____

2. Location of Practice _____

3. Please indicate the Limits of indemnity required for:

i. Malpractice	a. In respect of any one claim	SR	_____
	b. The aggregate amount during any one policy year	SR	_____
ii. Public Liability	a. In respect of any one claim	SR	_____
	b. The aggregate amount during any one policy year	SR	_____

NB1: 3(ii) above covering general Public Liability is optional on payment of additional contribution.

4. a. At what Medical School(s) did you qualify? _____
   b. In what year(s)? _____
   c. With what degree? _____

5. What branch(es) of the medical profession are you qualified and licensed to practice? E.g. General Practitioner, Dentistry, Anesthesiology, Surgery, Nursing, Lab Technicians etc.

   _____
   _____
   _____

6. Are you licensed in Saudi Arabia for the branch(es) of the medical profession you are practicing in Saudi Arabia?

   _____
   _____

7. a. Please name all partners and/or medically qualified employees. If none, state none:

   _____
   _____

   b. Please state the number of employed

   (i)Technicians _____ (ii) Nurses _____ (ii) Others (please specify) _____

NB2 The answers to Question 7 are for office use only as the Policy will indemnify the Proposer only. If it is your intention to cover the individual liability of any of the stated persons included in your answers you must advise and further forms will be provided for completion and quotation.

8. If you are not employed please indicate whether you are an employee of a Government Agency or the private Health care section. (Please give details)

   _____
   _____

9. Please advise whether you have had medical professional liability insurance during the past 12 months.

   If YES, please give the name of the Insurer Yes ☐ No ☐

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10. Has any Insurer ever cancelled, declined, refused to renew or only accepted on special terms your professional liability insurance?

    If YES, please give the name of the Insurer. Yes ☐ No ☐

    _____

11. Have you ever been convicted for an act committed in violation of any law or ordinate (other than traffic offenses) or been the subject of disciplinary proceedings or reprimand by any administrative agency or professional association?

    If YES, please give the name of the Insurer Yes ☐ No ☐

    _____

12. a. Have any claims or suits for negligence, error or omission been made against you?

    Yes ☐ No ☐

    b. Are you aware of any claims or suits for negligence, error or omission that may been made against any of your partners, assistants, nurses or technicians?

    Yes ☐ No ☐

    c. Are you aware of any circumstances which may result in any such claims or suit being made?

    Yes ☐ No ☐

    If your answer to any of the above is YES, please give full details.

    _____

    _____

DECLARATION:

I / We HEREBY DECLARE that, to the best of my/our knowledge and belief, the above statements and particulars are complete and true and that I/We have not mis-stated or suppressed any material facts. (A material fact is one which is likely to influence acceptance or assessment of this proposal. If in any doubt whether facts are material, they should be disclosed). Submitting this form shall be the basis of the contracts should a policy be issued.

Signature of Proposer: _____ Date: _____

Cover will be on a Claims Made Basis. This means the policy will only respond to Claims both against you and notified to during the period of insurance.