Galloways Professional Indemnity Cover Proposal Form

(Medical Practitioners)

I. General Data

1. Full Name of Proposer: _____

2. Business Address: _____

3. Educational Background:
a) Medical School of Graduation: _____
b) Year of Graduation: _____
c) Other Medical School(s) Attended (if any): _____
d) Year of Graduation: _____

4. Professional Practice Since Graduation:

- In _____ from _____ to _____
- In _____ from _____ to _____

5. Is the proposer duly licensed in accordance with law to practise at the address given under item 2?

- YES ☐ NO ☐

6. Is the proposer a member of any association?

- YES ☐ NO ☐

7. Is the proposer or assistant practising as:

- a) Physician ☐
- b) Surgeon ☐
- c) Cosmetic Surgeon ☐
- d) Anaesthetist ☐
- e) Gynaecologist ☐

- f) Urologist ☐
- g) Orthopaedist ☐
- h) Radiologist ☐
- i) Dentist ☐
- j) Any other (specify): _____

8. Is the proposer, partner, or assistant regularly involved in first-aid service?

- YES ☐ NO ☐

9. Names of Partners: _____
(Answer all questions individually for each partner)

10. Names of Qualified Medical Assistants: _____

11. Number of Technicians Employed: _____

12. Number of Nurses Employed: _____

13. Is the proposer under contract with or in the employ of any individual, firm, or corporation?

- YES ☐ NO ☐

14. Does the proposer own, wholly or in part, operate or administer any hospital, nursing home, or other institution where medical services are customarily rendered?

- YES ☐ NO ☐
  If YES, provide details including number of reserved beds:
  _____

15. Does the proposer own or operate X-ray machines or laser?

- YES ☐ NO ☐
  If YES, provide number, type, and whether used for diagnosis, treatment, or both: _____

16. Number of Patients Per Year: _____

II. Nature and Volume of Present and Foreseeable Future Activities

(To be filled as per current and planned practice)

III. Previous Insurance / Previous Claims

1. Has the proposer previously been insured?

- YES ☐ NO ☐
  If YES, specify:

Name of Insurer	Policy Period	Limit of Indemnity

2. Has a previous application been declined?

- YES ☐ NO ☐

3. Has a previous insurance:
a) Required increased premium? YES ☐ NO ☐
b) Required special restrictions? YES ☐ NO ☐
c) Been terminated/not renewed by an insurer? YES ☐ NO ☐

4. Have any claims or suits for malpractice been made against the proposer or any of his partners, assistants, nurses, or technicians during the past five years?

- YES ☐ NO ☐
  If YES, advise amount and background of each claim:
  _____

5. Is the proposer or any of his partners, assistants, nurses, or technicians aware of any circumstances or incidents which may result in a claim or claims?

- YES ☐ NO ☐
  If YES, provide details: _____

IV. Indemnity Required

1. Limit any one claim: _____
2. Limit in the annual aggregate: _____

Declaration:

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

Dated this day of: _____ 20__

For and on behalf of (insert name of proposer): _____

Signature of Partner or Principal: _____

Signed/Endorsed by Kenya Medical Association (KMA):
(Signed over KMA rubber stamp)
Name of Officer on behalf of KMA: _____

Agent/Broker Name: _____
Agent/Broker Code Number: _____

Galloways