SHARJAH INSURANCE COMPANY

Head Office, Post Box No. 792, Sharjah, United Arab Emirates
Tel: +971 6 568 6690, 568 3833, Fax: +971 6 568 6545
Dubai Office Tel: 04-3979796 Fax No: 04-3979704
Abu Dhabi Office Tel: 02-6774200 Fax No: 02-6772770
Web site: www.shjins.ae E-mail: sico@emirates.net.ae

PROFESSIONAL INDEMNITY INSURANCE
PROPOSAL FORM

MEDICAL MALPRACTICE

HOSPITALS

I. *General Data*

1. Full Name of Institution:
(Hereinafter referred to as "the Proposer") _____

_____

_____

2. Business Address: _____

_____

_____

3. Date of Establishment _____

	Yes	*No*
4. Is the Proposer		
a) approved by a public authority? Name of the authority and date of approval	☐	☐
b) a member of a hospital association? Name of the association and date of acceptance	☐	☐
5. Is the Proposer maintained in whole or in part by public or private funds or endosment?	☐	☐

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	_____	**100%**
b) Surgical	_____	**100%**
c) Gynaecological and obstetrical	_____	**100%**
d) Pediatric	_____	**100%**
e) Orthopedic	_____	**100%**
f) Dental	_____	**100%**
g) Psychiatric	_____	**100%**
h) Any other classes		
_____	_____	**100%**
_____	_____	**100%**
_____	_____	**100%**

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

	Numbers
a) Surgeons	_____
b) Cosmetic Surgeons	_____
c) Anaesthetists	_____
d) Gynaecologists	_____
e) Internal Specialist	_____
f) Urologists	_____
g) Orthopaedists	_____
h) Radiologists	_____
I) Ophthalmologists	_____
j) Dentists	_____
k) Physicians	_____
l) Interns (licenses and unlicensed)	_____
m) Others (please specify)	_____
_____	_____

		Numbers
6.	**Medical Assistants (pharmacists, laboratory technicians, etc.)**	_____
7.	**Number of Nurses**	
	a) Graduates	_____
	b) Undergraduates or students	_____
8.	**Number of beds (including for maternity cases)**	_____

		Yes	*No*
9.	**Does the proposer own or operate X-ray machines, lasers, ultrasound machines or similar equipment?**	☐	☐
	If so, please specify and give number of machines, type and whether they ar used for diagnosis or treatment or both. _____		
10.	**Does the Proposer use radioactive materials?**	☐	☐
	If so, please specify machinery and/or materials used. _____		
11.	**Does the Proposer operate a blood bank?**	☐	☐
	If so, please advise percentage use		
	a) for own purpose _____ %		
	b) for supply to other parties _____ %		

III. *Previous Insurance/Previous Claims*

	1. Has the Proposer previously been insured?	☐	☐

If so, please specify

Name of Insurer	Policy Period	Limit of Indemnity
1.		
2.		
3.		
4.		
5.		

	Yes	No
2. Has a previous application been declined?		
Has a previous insurance a) required increased premium?	☐	☐
b) required special restrictions?	☐	☐
c) been terminated/not been renewed by an Insurer	☐	☐

If so, please give detailed information _____

_____

_____

3. Have any claims or suits for malpractice been made during the past five years against the Proposer?	☐	☐

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?	☐	☐

If so, please give details _____

_____

_____

IV Indemnity Required

1. Limit any one claim _____

2. Limit in the annual aggregate _____

3. Deductible each & every claim to be borne by Insured. _____

I/We declare that the statements and particulars in this proposar 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 trhe basis of any contract of insurance effected thereon.

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

Dated this _____ day of _____ 200__.

For and behalf of
signature of partner or principal _____