PROPOSAL FORM OF PROFESSIONAL INDEMNITY POLICY FOR MEDICAL ESTABLISHMENTS

Marketing Officer

Branch Address

City / Town / Village

State Pin Code

Phone No. Business Sector Urban Rural Social

Proposal Form No Group I.D.No Client I.D.No

GUIDELINES FOR COMPLETION OF THE FORM

- Please answer all questions fully and correctly. Where any question does not apply, please mention clearly that the same is not applicable.
- Insurance is a contract of Utmost Good Faith requiring the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. If you think any fact is material, please disclose it.
- The Policy shall become voidable at the option of the Insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or on non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents, or any material information having been withheld by the proposer or any one acting on his behalf.
- Kindly contact the Company's Offices or Agents for any doubts or clarifications on the proposal form.

NOTE

The liability of the Company does not commence until this proposal has been accepted by the Company and premium paid.

SCOPE OF COVER

This insurance Policy indemnifies the Insured against legal liability of the Insured arising out of any breach of professional duty by reason of any negligent act, error or omission. It also covers legal costs and expenses incurred by the Insured, with prior consent of the Company and within the limit of indemnity, in the investigation, defence or settlement of such legal liability.

SIGNIFICANT EXCLUSIONS

This Insurance Policy does not cover liability arising out of cosmesis. It also does not cover any third party public liability as well as any financial loss, fines and penalties (punitive or exemplary). For other exclusions and limitations, kindly refer to the Policy.

NOTE

The foregoing is only an indication of the cover offered. For details, please refer to the Policy.

CLIENT INFORMATION

Proposer's name (please leave a space after each part of name)

Proposer's mailing address (please leave a space after each part of address)

City / Town / Village

State Pin Code

Phone No. Fax Number

E-Mail Address

Website

Name and address of owners / directors / partners (please leave a space after each part of address)

City / Town / Village

State Pin Code

Phone No. Fax Number

E-Mail Address

DETAILS: Put a (✔) mark wherever applicable

CLIENT INFORMATION

Website

Please state the year in which the establishment commenced operations _____

Do you wish to avail policy documents in physical form ☐ Yes ☐ No

Nominee Name

Relationship with the Insured

Mobile No. Email ID

Present & Permanent Address

Authorized person for Minor Nominee

Bank Details

Details of Multiple/Other insurance covering same risks with any other Insurance Company: _____

Type of Proposer ☐ Individual ☐ MSME/SME ☐ Partnership firm ☐ Company ☐ Govt. ☐ Others _____

Are you or any of the proposed applicants/beneficial owner a PEP* or Family member/ Close relatives/Associates of PEPs*?

☐ Yes ☐ No

If yes, please give details (Nature of relationship and position held by PEP):_____

**Politically Exposed Persons (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Government, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials.*

Risk Details

Please indicate the limit of indemnity required: Any One Accident[1] (AOA) (₹)

Please specify the ratio of AOA TO AOY[2] limit of indemnity:

1:1 ☐ 1:2 ☐

1:3 ☐ 1:4 ☐

Please specify Retroactive Date and Excess Details

Retroactive date	
Compulsory excess	
Voluntary excess (% of AOA)[3]	

Is the establishment registered with the competent authority? Y☐ N☐

If no, please specify the reason _____

Have you complied with all statutory and regulatory rules / regulations relating to the establishment? Y☐ N☐

Are the doctors / technicians/nurses practicing in the establishment duly licensed in accordance with prevalent laws? Y☐ N☐

Please state Name and Address of all Association(s)/Council(s) with which the establishment is registered, with Membership/Registration No. _____

_____

[1] AOA: Any One Accident relates to limit of liability in respect of any one accident

[2] AOY: Any One Year relates to limit of liability in respect of all accidents in any one year.

[3] Voluntary Excess: First portion of any loss that the Insured will bear. Please indicate the voluntary excess as percentage of limit of indemnity per accident, which will entitle you to a discount in premium.

Risk Details

Please specify the number of employees and visiting doctors in each of the following categories

Category	No.
General physicians.	
Specialists/ surgeons	
EYE/ ENT	
Pathologists	
Cardiologists	
Radiologists	
Plastic surgeons	
Dentists	
Pharmacists	
Technicians	
Nurses	
Trainees	
Any other (please specify)	
Total	

Please specify facilities such as dispensing facility, X-ray radiation therapy, scanning ECG, Sonography, MRI, etc. available/ operated in the establishment

S.No.	Facility	No. of units

Are these above specified facilities being maintained through regular service contracts with the manufacturers/authorised servicing agencies? Y ☐ N ☐

Are these facilities being operated by employees/ staff of the establishment? Y ☐ N ☐

If so please provide details as under

S.No.	Description of the facility operating the facility	Name of the employee the employee	Qualification of in operating the facility	Years of experience

Do 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? Y ☐ N ☐

Are these facilities being operated by employees/ staff of the establishment? Y ☐ N ☐

Is the establishment under care/management/supervision of a qualified doctor and/or a nurse at all times? Y ☐ N ☐

If so, please give details:

Please state the number of patient beds including bassinettes maintained

Please provide the following details about number of beds now available

- ☐ Emergency Ward Beds
- ☐ Day Surgery Beds
- ☐ Maternity Beds
- ☐ Other Hospital Beds
- ☐ Nursing Home Beds
- ☐ Others - please give details _____

Please specify the overall occupancy rate for all the beds maintained during the last 12 months?

Please state the number of fully equipped operation theatres

Do you have an out patients department? Y ☐ N ☐

Risk Details

If so please specify, number of patients actually treated in the previous year and number of patients estimated to be treated in the current year _____

Please provide the approximate division of in - patients between:

	Current year	Previous year
General/ Medical		
Surgical (major)		
Surgical (minor)		
Day Surgery		
Senile or Aged		
Palliative		
Psychiatric		
Drug/Alcohol dependency		
Elective Cosmetic		
Obstetrics/Maternity		
Allied Health Therapy		
Casualty/Emergency		
Other (please specify)		

What diagnosis or surgical procedures are performed other than as referred to in Question 14?

Please give details of the radioactive treatment facilities used in the establishment. Please specify the materials used and precautions taken for such usage

In case food is supplied by you to patients, please specify whether it is prepared in the establishment or catered. Please specify the measures taken for maintenance of kitchen and other supervisory measures

Do you ensure compliance with documented risk management and quality control procedures? Y ☐ N ☐

Are these risk management procedures regularly reviewed and updated to the appropriate standards applicable to the industry? Y ☐ N ☐

Does your staff attend regular education and/or training programmes? Y ☐ N ☐

Please specify details as under

Annual income	In the Proposed year of insurance	In the Preceding year
Room charges		
Operation theatre charges		
Medicine		
X ray charges		
Doctor's fees		
Nursing charges		
Any other		
Total		

Have any claims been made against the establishment or legal proceedings instituted or likely to be instituted against the establishment in respect of services rendered by the establishment? Y N

If so, please give details _____

Are you aware of any neglect, omission or error or existence of any circumstances likely to give rise to a legal claim? Y N

If so, please give details _____

Have you been previously insured against professional liability? Y N

If so, give full particulars _____

Has any insurance Company declined your proposal? Y N

Required an increased premium? Y ☐ N ☐

Refused to renew your policy? Y N

Canceled such a policy? Y N

Risk Details

Any additional information relevant to the Policy

Note: Please use additional sheets if space is not sufficient to complete details

BANK DETAILS

Refund of Premium (Policyholder/Proposer)

Account Holder Name

Bank Name

Account No. IFSC Code

DECLARATION WHEN THE PROPOSAL FORM IS FILLED BY A PERSON OTHER THAN THE PROPOSER/ THE PROPOSER SIGNS IN A VERNACULAR LANGUAGE/ PROPOSER IS ILLITERATE

- I hereby declare that I have read out and explained the content of this proposal form and all other connected documents incidental to availing the insurance policy from ICICI Lombard GIC ltd. to the proposer and that he/she confirmed that he/she has understood the same and he/she agrees to abide by all terms and conditions of the same.
- I hereby declare that I have fully explained to the proposer the answers to the questions that form the basis of the contract of insurance have also explained the contents in this form to the proposer in _____ language, that I have truly correctly recorded the answers given by the proposer and that the proposer has fixed his/her thumb impression on the proposal form in my presence, after fully understanding the contents thereof. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.
- I hereby state that the contents of the form and documents have been fully explained to me and that I have fully understood the significance of the proposed contract.

Name of the Proposer

Name of the Witness

Signature of Proposer	Signature of Witness

Place: _____ Date D D M M Y Y Y Y

Relationship with Proposer

Address of Witness

Declaration

- I/We agree that the Policy shall become voidable at the option of the Company, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure in any material particular in the proposal form/personal statement, declaration and connected documents, or any material information has been withheld by me/us or anyone acting on my/our behalf to obtain any benefit under this Policy.
- I/We, the undersigned hereby declare and warrant that the above statements are true, accurate and complete. I/We desire to effect an insurance as described herein with the Company and I/We agree that this proposal and declarations hereto shall be the basis of contract between me/us and the Company and I/We agree to accept a Policy subject to the conditions prescribed by the Company.
- I/We agree that the issuance of Policy/Cover Note shall be subject to realisation of premium cheque.
- I/We hereby agree and confirm that if the amount collected is less than the premium quoted or revised as per changes in sum proposed for insurance or scope of cover desired by me/us, the proposal shall be considered for acceptance for a reduced sum appropriate to the premium collected and the Policy shall be finalised accordingly.
- I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.
- I/We hereby declare and confirm that the premium has been paid out of legally acquired sources of income and the subsequent premiums if any, will continue to be paid out of legally declared and assessed source of income.
- I/We understand that the Company has right to call for documents to establish source of funds
- I/We hereby declare that the details furnished above are true and correct to the best of my/our knowledge and belief and I/we undertake to inform you of any changes therein, immediately, not later than 30 days.
- In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am/we are aware that I/we may be held liable for it.

Place :

_____
Proposer's Signature & Company Stamp

Date : D D / M M / Y Y Y Y

_____ _____
Name Designation

INTERMEDIARY DECLARATION AND DETAILS/PRINCIPAL OFFICER DETAILS

I, _____<full name> in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/ Insurance Sales Persons of Insurance Marketing Firm / Broker Qualified Person/ Point of Sales Person/ Designated Person/ Authorised Verifier or any other authorised salesperson/ Rural Authorized Person (RAP) and Village Level Entrepreneur – Ins (VLE-Ins) of Common Public Service Centre do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to cancel the policy at its discretion. Further, this declaration does not confirm issuance of policy or assumption of risk thereof.

_____ (to be filled in, only in case there is some disclosure to be made).

I hereby confirm to the best of my knowledge and belief that there is no inconsistency or adverse habits that may affect the underwriting of this proposal except as mentioned below:

Intermediary Name / Principal Officer Name: _____ Code/Functional Identity: _____

Contact No. of the branch: _____ Email ID of the branch: _____ Branch/Office: _____

STATUTORY WARNING

PROHIBITION OF REBATES

(Under Section 41 of Insurance Act 1938)

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to (take out or renew or continue) an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing [or continuing] a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

(Provided that acceptance by an insurance agent of commission in connection with a policy of any class of insurance business taken out by himself in relation to risks associated with his own life, health or property shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.)

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.