PROPOSAL FORM OF HEALTH CARE & MEDICAL PROFESSIONAL LIABILITY

GUIDELINES FOR COMPLETION OF THE FORM (To be filled by the insured)

1. Please answer all the questions fully and correctly. Where any question does not apply, please mention clearly that the same is "**NOT APPLICABLE"**.
2. Insurance is a contract of utmost good faith requiring the insured to disclose all material facts in response to the questions in the proposal form. This obligation continues until the policy is expired and does not end with the submission of this proposal form. If therefore, there is any change in the information given herein or new information comes to light before the policy expires, then insured must inform the Company of the same in writing without delay.
3. The Policy shall become void at the option of the insurer, in the event of any untrue or incorrect statement, misrepresentation, non-description or non-disclosure of any material fact, particularly in the proposal form/personal statement, declaration and connected documents or any material information having been withheld by the insured.
4. Kindly contact the Company's offices or Agents / Intermediaries for any doubts or clarifications on the proposal form.
5. ILGIC means ICICI Lombard General Insurance company limited

Section 1: Policyholder Details

Name (Doctor/ Medical Establishment/ Healthcare Professional):	
Address (with Pin code)	
Gender (if applicable)	Male ☐ Female ☐ Third Gender ☐
Status (applicable in case of an entity)	Private Limited Co ☐ Public Ltd. Co ☐ Unincorporated Association or Body of Individuals ☐ Partnership/LLP ☐ Trust/ Foundation ☐ Others (please specify) _____
Occupation Details (applicable in case an individual)	Salaried ☐ Self Employed/ Business ☐ MSME/SME Other (Please specify) _____
Mobile number	

Email id	
GSTIN number (if applicable)	
Aadhaar number	
Website Address	
Do you wish to avail policy documents in physical form	
Nomination	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 risk with any other Insurance Company	

Declarations

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

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.*

Any other information:

Section 2: Policy Details

Limit of Liability/ Sum insured	**At one event**	**In the Aggregate**
Ratio of AOA TO AOY limit of indemnity [1]*AOA: relates to limit for each and every claim* [2]*AOY: relates to limit for all losses in aggregate for the policy tenure*	1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ If the Full limit of Liability/Sum insured needs to offered for all claims, then select 1:1 or else select the other options. If No selection is made, then 1:1 will apply.	

Policy Period required (DD/MM/YYYY):	From____/___/_____ To ____/___/_____	
Policy Tenure (in years)	1 ☐ 2 ☐ 3 ☐	
Territory required:	India ☐ Worldwide including USA/ Canada ☐ Worldwide excluding USA/ Canada ☐	
Type of Policy	New ☐ Renewal ☐	
In case of ILGIC renewal, please mention previous Policy Number		
Base Covers **Professional Liability** **Advancement of Defence Costs**		
Extensions (All Limits mentioned below will be part of the sub limits of the policy and not over and above of the Limit of Liability/ Sum Insured) **Contractual Liability** **Breach of Privacy and Confidentiality** **Extended Reporting Period** **Spouses, Estates & Representatives** **Good Samaritans Cover** **Lost Documents**		**Sub-limit (INR)**
•		
• Lost Documents		
Optional Extensions:	**Required/ Not Required**	**Sub-limit (INR)**
a) Public Relations Costs	Yes ☐ No ☐	
b) Visiting Medical Professional	Yes ☐ No ☐	
c) Professional Inquiries	Yes ☐ No ☐	
d) Molestation Defence Costs and Inquiry Costs	Yes ☐ No ☐	
e) Run-Off Cover	Yes ☐ No ☐	
f) Dishonesty of Employees	Yes ☐ No ☐	
g) Medico-Legal Consultation	Yes ☐ No ☐	
h) Students and Volunteers	Yes ☐ No ☐	
i) Participation in Clinical Trials	Yes ☐ No ☐	

Section 3: Risk details - Individual Doctor/Healthcare Professional

1. Please furnish below details:

Health Professional ID	Field of specialisation	No. of years in practice	Registration No.	Educational Qualification	Date of Passing (DD-MM-YYYY)

Comments (if any):

_____

Section 4: Risk Details - Medical Establishment

1. Please provide the following details about number of beds now available:

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

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

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

Category	Count
General physicians	
Specialists/ surgeons	
EYE/ ENT	
Pathologists	
Cardiologists	
Radiologists	
Plastic surgeons	
Dentists	
Pharmacists	
Technicians	
Nurses	
Trainees	
Any other (please specify)	
Total	

4. Do you have an out patients department? Yes ☐ No ☐

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

_____

5. 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		

6. What diagnosis or surgical procedures are performed other than as referred above?

7. Please specify details as under:

Annual Income	In the proposed year of insurance	In the preceding year of insurance
Room charges		
Operation theatre charges		
Medicine		
X ray charges		
Doctor's fees		
Nursing charges		
Any other		
Total		

Section 5: Claim Experience / Previous Policy History

Please share details of previous polices and claims (If any) in the past under any policy with similar covers with the company or any other insurer in the past:

Policy Period (From And To) (DD-MM-YYYY)	Name and Address Of Insurer	Policy Number	Total Claim Amount (INR)	Claim Details

Note: Please attach a separate sheet if space available is not sufficient for filling in complete details. Any additional information material to assumption of risk.

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

Yes ☐ No ☐

If so, please give details

Has any insurance Company declined your proposal? Yes ☐ No ☐

Cancelled such a policy? Yes ☐ No ☐

Any additional information relevant to the Policy

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

Relationship with Proposer

Address of Witness

Date:

Place: Signature of the Proposer Signature of the Witness

1. I/We hereby confirm that we have documented risk management and quality control procedures, same are reviewed and updated on a regular basis.
2. I/We hereby declare, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and belief and that if, after the insurance is effected, it is found that any of the statements, answers or particulars are incorrect or untrue in any respect, the Company shall have no liability under this insurance.
3. I/We understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
4. I/We agree and undertake to convey to ICICI Lombard General Insurance any additions/ alterations carried out in the risk proposed for insurance after submission of this proposal form.
5. I/We authorize the company to share information pertaining to my proposal including the contents of the claim documents for the sole purpose of underwriting the proposal and/or claims settlement and with any Governmental and/or Regulatory authority.
6. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.
7. 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.
8. I/We understand that the Company has right to call for documents to establish source of funds
9. 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.
10. 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. Further, I/We understand that the Company has a right to cancel the insurance contract in case, I am/have been found guilty by any competent court of law under any statutes, directly or indirectly governing the prevention of money laundering.
11. I/We have been provided with the detailed terms of the policy. I have read, understood and aware of the details terms of the policy.
12. I/We declare that the contents of this proposal form and other documents have been fully explained to me and I have fully understood the significance of the proposed contract.

Date: ___/___/_____ Place:

_____

Insured Signature: _____

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)

(Amendment Act 2015)

(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.