



## PROPOSAL FORM FOR MEDICAL ESTABLISHMENTS ERRORS & OMISSIONS INSURANCE

This proposal must be signed. All questions must be answered. The completion and signature of this proposal does not bind the Proposer or Insurer to complete a contract of Insurance.

If there is insufficient space to answer questions, please use additional sheets and attach it to this form.

The Company does not assume any liabilities until the Proposal has been accepted and premium paid.

- 1) Name of the Proposer \_\_\_\_\_  
Address \_\_\_\_\_
- 2) Year in which established \_\_\_\_\_
- 3) Name & Address of owners/directors/partners \_\_\_\_\_
- 4) a) Is the Establishment registered with the local competent authority? If no, why? \_\_\_\_\_  
b) Have you complied with all statutory rules/regulations relating to your establishment? \_\_\_\_\_
- 5) i) Are the Doctors/Technicians working for you \_\_\_\_\_  
a) duly licensed in accordance with the Medical Acts or any other prevalent laws \_\_\_\_\_  
b) Members of Medical Association/Council \_\_\_\_\_  
ii) Do you employ only qualified Nurses? \_\_\_\_\_
- 6) State the no. of employees and visiting doctors in each of the following classifications :
  - 1) General Physicians \_\_\_\_\_
  - 2) Specialists including surgeons in different disciplines. \_\_\_\_\_
    - a) Eye/ENT \_\_\_\_\_
    - b) Pathologists \_\_\_\_\_
    - c) Cardiologists \_\_\_\_\_
    - d) Radiologists \_\_\_\_\_
  - 3) Plastic Surgeons \_\_\_\_\_
  - 4) Dentists \_\_\_\_\_
  - 5) Pharmacists \_\_\_\_\_
  - 6) Technicians \_\_\_\_\_
  - 7) Nurses \_\_\_\_\_
  - 8) Trainees \_\_\_\_\_
  - 9) Other (Please specify) \_\_\_\_\_
- 7) a) Please specify all the facilities available like x-ray, Scanning, Pathology, etc. \_\_\_\_\_  
b) Whether persons operating these are qualified and well experienced \_\_\_\_\_  
c) Do you wish to extend the policy to cover the personnel who are not professionally qualified to operate the facility assigned to them? If yes, please give names of the personnel and the facility operated. \_\_\_\_\_

- d) Is the establishment under care of qualified doctor round the clock? \_\_\_\_\_
- e) Is a qualified nurse in attendance round the clock? \_\_\_\_\_
- 8) a) Please state the no. of beds including bassinets maintained by you. \_\_\_\_\_  
 b) State no. of fully equipped operation theatres \_\_\_\_\_
- 9) Do you have an out-patients department? Please specify :  
 a) No. of patients actually treated in the previous year \_\_\_\_\_  
 b) No. of patients estimated to be treated in the proposed year \_\_\_\_\_
- 10) Please state the following particulars regarding the in-patients treated

Proposed Year	Immediately	(Est - Preceding imated) (Actual)
a) General		
b) Medical		
c) Surgical		
<b>Total:</b>		

- 11) Give details of radioactive treatment facility. Specify the materials used and precautions taken for such usage \_\_\_\_\_
- 12) Whether food is supplied by you to patients? If yes, specify whether it is prepared by you or contractors. Please specify the measures taken for maintenance of kitchen and other supervisory measures \_\_\_\_\_
- 13) State estimated annual income includes room charges, Operation Theatre, Rent, charges for X-ray facilities, doctor's fees, nursing charges, medicines, food, surcharge and any other income. \_\_\_\_\_
- 14) Details of any claims lodged against the proposer during the past 5 years on account of services rendered by your establishment \_\_\_\_\_
- 15) Have you ever insured against liabilities in the past? If so, specify the name of the insurer, policy no. and period \_\_\_\_\_
- 16) Has any insuree cancelled/ declined/refused to renew your liability insurance or accepted your proposal subject to restrictions. \_\_\_\_\_
- 17) Details of any event likely to give rise to a liability claim against you at a future date. \_\_\_\_\_
- 18) State limits of indemnity required - for  
 Any One Act (AOA) Rs. \_\_\_\_\_  
 Any One Year (AOY) Rs. \_\_\_\_\_
- 19) Period of Insurance required From : \_\_\_\_\_ To : \_\_\_\_\_
- 20) Voluntary Excess \_\_\_\_\_



I/We do hereby declare that the above statements and answers are true and that I/We have not withheld any information whatsoever regarding the proposal. I/We hereby declare that all statutory provisions relating to my/our business proposed for insurance are complied with. I/We agree that this proposal and declarations shall be the basis of the contract between me/us and ..... Co.Ltd. whose Policy for the Insurance proposed is acceptable to me/us. I/We undertake to exercise all ordinary and reasonable precautions for safety of the property as if it were uninsured.

Place : \_\_\_\_\_

Date : \_\_\_\_\_

Signature of Proposer

#### DEVELOPMENT OFFICER'S REPORT.

The Proposer is known to me/my Agent for \_\_\_\_\_ years and I recommend acceptance of this proposal.

Place : \_\_\_\_\_

Date : \_\_\_\_\_

Signature of Development Officer

Name and Code No. of Development Officer \_\_\_\_\_

#### Note :

- 1) The liability of the Company does not commence until the proposal has been accepted by the Company and the premium paid
- 2) Premium will be quoted on application

### SECTION 41 OF THE INSURANCE ACT, 1938

#### PROHIBITION OF REBATES

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 or 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 continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.
2. Any person making default in complying with the provisions of this Section shall be punishable with fine which may extend to Rs. 500/-.