التكافل للتأمين
AL-TAKAFUL INSURANCE
خدمات تأمين إسلامية

MEDICAL MALPRACTICE INSURANCE PROPOSAL FORM

- INDIVIDUAL PRACTITIONERS -

INSTRUCTIONS

Please read the following instructions and notices before completing this proposal form.

- Type or write clearly
- **ANSWER ALL QUESTIONS COMPLETELY TO AVOID DELAY IN QUOTATION**
- If there is insufficient space to completely answer a question, continue on a separate sheet of your firm's letterhead indicating the number of the question.
- The form must be signed and dated **by the individual**

IMPORTANT NOTICE

It is your duty to disclose all material facts to Underwriters. A material fact is one that is likely to influence an Underwriter's judgement and acceptance of your proposal. If your proposal is a renewal, it should also include any change in facts previously advised to Underwriters. If you are in any doubt about facts considered material, disclose them. **FAILURE TO DISCLOSE** could prejudice your rights to recover in the event of a claim or allow Underwriters to void the policy. If a contract of insurance is agreed, this proposal form will form the basis of the contract.

Any insurance contract (policy) that may be offered on the basis of this proposal form will provide insurance on a "claims made" basis. This means that the policy indemnifies you for claims made against you and notified to the Insurer during the period of policy. The policy does not provide indemnity in relation to:
events that occurred prior to the retroactive date, if any, specified in the policy;
claims notified or arising out of circumstances notified under any previous policy;
claims made against you prior to the commencement of the period of insurance;
claims made against you after the expiry of the period of insurance;
claims arising out for circumstances noted on this proposal form or any previous proposal forms;
claims arising out of any facts or circumstances known to you at the commencement of the period of insurance where such facts or circumstances would have put a reasonable person in your position on notice that a claim may be made against you in the future.

Section A – General Information

1. Name and principal address of the insured:

_____

_____

2. State your specialty from the below table (please mark ✓ next to your specialty):

Acupuncture Physicians		Cardiologist	
Ayurvedic Massage Therapist		Clinical Pathologist	
Ayurvedic Physicians		Clinical Pathologists	
Beauticians Therapist without laser treatments		Dentist	
Behaviour Therapists		Gastroenterologist	
Dieticians		Histopathologists	
Occupational and physical Therapist		Homeopathy Physicians	
Physiotherapists		Internal Medicine	
Reflexology Physicians		Neurologist	
Speech Therapists		Ophthalmologist	
Sports Physiotherapist - excluding professional athletes		Orthodontist	
Assistance Nurse		Pathologists	
Beauticians Therapist laser treatments		Periodontics	
Dental Assistant		Psychologists	
Dental Technicians		Unani Physicians	
Dermatologist		Urologist	
Lab Technicians		Sonographer/radiographer non-prenatal	
Medical Assistants		radiologist non-prenatal	
Nurses		Anaesthetists non-spinal tap/epidural	
Pathology Technicians		Critical Care Medicines	
Practical Nurse		Gastroenterologist (ex bariatric surgery)	
Prosthodontist		General Practitioners	
Psychiatrists		Implantologist	
Radiology Physicians		Urologist	
Scanning Technicians		Sonographer/radiographer	
School Nurses		Radiologist	
X-Ray Technicians		Oral & Maxillofacial surgeon	
Ambulance Physicians		Orthopaedic surgeons - non spinal	
Anatomic Pathologists		Plastic Surgeons – reconstructive	

3. Please state your estimated annual income for the upcoming year (USD): $_____

Section B – Treatment Statistics

1. State the main surgical procedures:

__

_____

2. State the main non-surgical procedures:

_____

_____

3. Do you offer obstetrical services? (*bearing in mind that this type of activity is not covered under our policy*)

YES ☐ NO ☐

4. Number of patients per year:

Inpatient: _____

Outpatient: _____

Section C – Information about Quality Management and Risk Management

Did you implement any elements of Quality Management and / or Risk Management? Please give details

_____

_____

_____

Section D – Information about the insurance and claims history

1. Identify the present Insurer(s), Limit of indemnity, Deductible, premium and expiry date (if applicable):

_____

_____

_____

2. Has any application for this type of insurance cover ever been

a) declined? YES ☐ NO ☐

b) cancelled? YES ☐ NO ☐

c) required special terms? YES ☐ NO ☐

If the answer to any of the above is YES, please give details:

_____

_____

3. Kindly provide us with the following information with respect to the new policy:

- Limit of Indemnity (*please mark* ✓ next to the requested limit of indemnity)*:*

USD 125,000.- Any one occurrence and in the aggregate	
USD 125,000.- Any one occurrence and **USD 250,000.-** in the aggregate	
USD 125,000.- Any one occurrence and **USD 500,000.-** in the aggregate	
USD 125,000.- Any one occurrence and **USD 1,000,000.-** in the aggregate	
USD 250,000.- Any one occurrence and in the aggregate	
USD 250,000.- Any one occurrence and **USD 500,000.-** in the aggregate	
USD 250,000.- Any one occurrence and **USD 750,000.-** in the aggregate	
USD 250,000.- Any one occurrence and **USD 1,000,000.-** in the aggregate	

- Deductible: USD 2,500.- each and every loss
- Retroactive date: Your retroactive date will be **inception of the policy** unless you currently hold medical malpractice insurance. In this case please state the retroactive date on your current policy

_____

4. Do you ensure that you are duly licensed and registered in your specific field?

YES ☐ NO ☐

5. List any claims made against yourself during the last 10 years:

Date of Accident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the allegations and details of Claimant and relevant Insurer

6. List any circumstances / complaints which may give rise to a claim being made against yourself:

Date of Circumstance / Complaint	Details including nature of the Complaint and details of the Complainant

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. I/We undertake to inform Insurers of any material alteration to these facts whether occurring before or after completion of the Contract of Insurance. Signing this Proposal Form does not bind the Proposer or the Insurers to complete this Insurance.

Name of Insured: _____

Signature: _____

Date: _____