PROFESSIONAL INDEMNITY FOR MEDICAL PRACTITIONERS INSURANCE PROPOSAL FORM

Please complete this form in BLOCK letters and fax/email it to our offices. Please attach a separate sheet(s), if required.

I. GENERAL DATA

1. **Full Name** ______________________
2. **Business Address** ______________________
3. **UAE Medical Association No.** ______________________
4. **Required Limit of Indemnity** ______________________
5. **a) At what medical school / university did the proposer graduate and when?**

____

b) Professional Qualification Acquired

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6. **Where and when has the proposer practiced his profession since graduation?**

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II. NATURE AND VOLUME OF YOUR PRESENT AND FORESEEABLE FUTURE ACTIVITIES

1. **The proposer is practicing as** ______________________
2. **Name(s) of qualified medical assistant(s) / technician(s)** ______________________
3. **Number of technicians employed** ______________________
4. **Number of nurses employed** ______________________
5. **Is the proposer under contract with or employed by any individual, firm or corporation? If so please give details.**

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6. **Does the proposer own, wholly or in part, operate or administer any hospital, nursing home or other institution? If so, please give details including number of reserved beds.**

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7. **Does the proposer own or operate x-ray machine or laser? If so, please give number, type and whether they are used for diagnosis or treatment or both.**

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8. **Number of patients per year** ______________________

Abu Dhabi: Sky Tower, Al Reem Island, 9th Floor, Office 904 & 905, P.O. Box 32380, Abu Dhabi – UAE, Tel.: 02-6449915, Fax: 02-6449934
Dubai: Al Warsan Building, 8th Floor, Office 803, Near Media Rotana Hotel, Tecom, P.O. Box 31130, Dubai – UAE, Tel: 04-4534700, Fax: 04-4534701
E-mail: primeins@primeinsbrokers.com

III. PREVIOUS INSURANCE / PREVIOUS CLAIMS

1. If the proposer has been previously insured please specify:

Name of the Insurer ______________________

Policy Period ______________________

Limit of Indemnity ______________________

Deductible ______________________

2. Has a previous application been declined? Yes / No
If yes, please give details.

____

3. Has a previous Insurer required increased premium or special restrictions? Yes / No
If yes, please give details.

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4. Has a previous insurance been terminated / not been renewed by an Insurer? Yes / No
If yes, please give details.

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5. Have any claims or suits for malpractice been made against the proposer or any of his partners, assistants, nurses or technicians during the past five years? Yes / No
If yes, please give details.

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I declare that the statement and particulars in this proposal are true and that I have not misstated or suppressed any material facts. I agree that this proposal, together with any other information supplied by me, shall form the basis of any contract of insurance effected thereon. Signing this proposal form does not bind the proposer or the Company to complete the insurance.

DATE:

SIGNATURE:

NAME: COMPANY STAMP

DESIGNATION / TITLE:

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