PIONEER GENERAL INSURANCE CO. LTD.

PIONEER GENERAL
Your Security For The Future

PROFESSIONAL INDEMNITY MEDICAL MALPRACTICE LIABILITY INSURANCE PROPOSAL FORM

M-PESA Paybill
Business No: 100500

Account No. _____ **Policy No.** _____

Agency / Broker: _____

Period of Insurance: From): _____ To: _____

INSTRUCTIONS:

- This Proposal form has been compiled in such a manner as to provide Insurers with as much detail as possible with regard to evaluation of the Insurance requirements. Completion of this form does not bind the Proposer or Insurers to complete the insurance transaction.
- To assist Insurers in accurately assessing liability for rating purposes, Proposers are requested to answer all the questions with either: Relevant Details, "YES", "NO" or "NIL" answers. Where YES/NO answers are required, please mark the appropriate box with an "X".
- Please answer ALL questions fully, replies such as "see your records", or "as previously advised" are not acceptable.
- If the space provided is insufficient, a separate sheet should be attached.

SECTION 1: PERSONAL DETAILS

a. Full Name of Proposer: Surname _____ Other Names _____

b. Contact Details: (tel): _____ (fax): _____

(mobile): _____ (web): _____

(email): _____

(postal): _____ (code): _____ (town/city): _____

c. Proposer PIN Number: | | | | | | | | | | | | ID No. | | | | | | | | | |

d. VAT Registration Number: _____

e. Present Legal Constitution: (*mark relevant box below*)

- ☐ Sole Practitioner
- ☐ Partnership
- ☐ Incorporated Company
- ☐ Limited Company
- ☐ Close Corporation

SECTION 2: ADDRESS OF THE PRACTICE:

2.1 PRINCIPAL OFFICE:

(Postal): _____ *(Code):* _____ *(Town/City):* _____

(Partner / Principal in charge): _____

2.2 SUBSIDIARY OFFICE:

(Postal): _____ *(Code):* _____ *(Town/City):* _____

(Partner / Principal in charge): _____

SECTION 3: DATE OF COMMENCEMENT OF PRACTICE:

3.1 As currently constituted: _____

3.2 As initially established _____

4. DISCIPLINE(S) IN WHICH ENGAGED: _____

5. NAMES AND QUALIFICATIONS OF PRINCIPALS:
   i. In the case of Partnerships – Partners
   ii. In the case of Incorporated Companies – Directors
   iii. In the case of Limited Companies – Professionally Qualified Directors and Employees
   iv. In the case of Close Corporations – Members

Name	Qualifications	Date Qualified	How long Principal in this Practice

6. Have any claims ever been made against the proposed Insured / Partners / Directors / Members or Employees for the type of cover for which you are now applying? Yes: ☐ No: ☐
If YES, please give details;

7. Are any of the Proposed Insured / Partners / Directors / Members or Employees AFTER ENQUIRY; aware of any circumstances which would be covered under a policy of this type that may result in any claims or a possible claim being made against them? Yes: ☐ No: ☐
If YES, please give full details (attach page to the back if necessary);

8. Are you at present or have you in the past been Insured? Yes: ☐ No: ☐
If YES, please state;
   a) Name of Insurers
   b) Indemnity Limit
      Excess of KShs. Each and every claim
   c) Date of Expiry of coverage
   d) Whether Policy includes “Run-Off” Cover
      And if so, for what period

9. Is indemnity to apply to any Principal who has left / retired / died? Yes: ☐ No: ☐

Name	Qualifications	Date Qualified	How long Principal in this Practice
			Yes: ☐ No: ☐

1: STAFF COMPLEMENT

Please state the number of employees in each of the following classifications:

1.1 Medical Staff:

	Category / classification	Number	Specializing in;
a)	Surgeons		
b)	Doctors of Medicine		
c)	Radiologists		
d)	Radiographers		
e)	Laboratory Technicians		
f)	Pharmacists		

1.2 Nursing Staff:

Name of Director of Nursing	Qualifications	Year(s) Obtained

(a) Number of Auxiliary Nurses: _____ (b) Number of Student Nurses: _____

2 Please state your immediate past Financial Year End: _____

2.1 Please State:

	Details	Immediate Past Financial Year End	Previous Financial Year End
a)	Gross Revenue of the Hospital / Clinic		
b)	Gross Revenue relating to Rentals / Leases etc.		
c)	Gross Revenue from Medical Procedures / Pharmacies or any other Medical Treatment		
d)	Gross Revenue from any other source. (Give brief details).		

3. **QUOTATIONS REQUIRED:**

a)

Amount:	**Limit of Indemnity**
KShs.	Any one period of Insurance inclusive of costs and expenses.
KShs.	Any one period of Insurance inclusive of costs and expenses.
KShs.	Any one period of Insurance inclusive of costs and expenses.
KShs.	Any one period of Insurance inclusive of costs and expenses.

b) DEDUCTIBLE (EXCESS)
The amount carried by the Insurer per claim)

Amount:	Excess
KShs.	Each and every claim
KShs.	Each and every claim
KShs.	Each and every claim
KShs.	Each and every claim

4. FEE INCOME
(This question must be completed accurately as the figures are used for rating purposes)

a) Please give gross fees received during the past five years:

Gross Fees	Year
KShs.	
KShs.	
KShs.	
KShs.	
KShs.	

b) Please give the estimated fees for the coming 12 months. KShs. _____

5. Does the Insured wish to be indemnified for liabilities resulting from AODS or any syndrome connected therewith? Yes: ☐ No: ☐

6. Is there any further information that should be made known to the Company in order that they may form a proper estimate of the risk? Yes: ☐ No: ☐
If YES, give details;

_____

_____

_____

Please attach any relevant publications or brochures

DECLARATION:

I/We warrant that the above statements are true, and I/We have not withheld or concealed anything affecting the proposed insurance, and that I/We agree that this proposal and declaration shall be the basis of the Contract between Pioneer General Insurance Co. Limited and myself/ourselves. I/We also agree to accept the Company's Policy applicable to the Insurance.

Signature of Proposer: _____ Date: _____

Liability does not commence until acceptance of the proposal has been intimated or official cover note issued.