PIONEER GENERAL INSURANCE CO. LTD.

SURGEONS PROFESSIONAL INDEMNITY INSURANCE PROPOSAL

M-PESA Paybill
Business No: 100500

PIONEER GENERAL
Your Security For The Future

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

PROPOSAL DETAILS

1. a) At what Medical School did you attain your Qualifications? _____

   b) In what year did you qualify? _____

   c) What degree did you obtain? _____

2. State whether you practice as: (*Please Tick Appropriate Speciality*)

Abdominal Surgeon	☐	Orthopaedic Surgeon	☐	Radiologist/ Roentgenologist	☐
Cardiologist	☐	Otorhinolaryncologist	☐	Thoracic Surgeon	☐
Cardio-Vascular Surgeon	☐	Pathologist	☐	Urologist	☐
General Surgeon	☐	Physician	☐	.....	☐
Neuro-Surgeon	☐	Physician & Non-specialist Surgeon	☐	.....	☐
Obstetrician & Gynaecologist	☐	Plastic Surgeon	☐	.....	☐
Oncologist	☐	Proctologist	☐	.....	☐
Ophthalmologic Surgeon	☐	Psychiatrist	☐	.....	☐

3. a) Name of Partners;
   (For Insurance purposes, each Partner is required to complete a Proposal Form)

   _____

   _____

   _____

   _____

   _____

   _____

   b) If you are the employee of a practice;
   (i) What is its title?

   _____

   (ii) Name all other employees of the corporation

1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

   c) If you are not the employee of a practice, please;
   (i) Name all Qualified Assistants (each must complete a proposal form).
   (ii) Names of Nurse Anaesthetists (with qualifications).
   (iii) Names of Other Nurses (with qualifications).

Name	Career Type	Qualifications

d) Do you require any of your employees to be named insured's? Yes: ☐ No: ☐
If YES, please give details;

4. Where have you practiced your profession since graduation and what year(s)?

Practiced Profession	Year(s)

5. Are you duly licensed in accordance with Law to practice at the address(es) specified in Section 2 of Part 1? *(Professional Indemnity General Information Form)* Yes: ☐ No: ☐

6. Of what Professional Associations or Societies are you a member in good standing?

7. Do you advertise your Business or Profession;
(a) Other than as permitted by your National or Local Professional Association or Society? Yes: ☐ No: ☐
(b) Other than by an entry in the Yellow Pages giving only your address and telephone number? Yes: ☐ No: ☐
If YES, please give details;

8. State approximate division of your work and indicate if you require coverage for the following;

No.	Work	Cover Required? (Indicate by "YES")	% of Total Work Performed
1	The prescription or fitting of Contact Lenses		
2	Hypnosis		
3	The treatment of mental illness, drug addiction or alcoholism		
4	Diagnostic X-Ray Procedures (other than plain X-ray)		
4-a	Angiographic procedures and Cardiac Catheterization		
b	Administration of Spinal, Caudal, Epidural or General Anaesthesia		
5	Plastic Surgery (other than minor skin grafts)		
5-a	Traumatic		
b	Cosmetic		

No.	Work	Cover Required? (Indicate by "YES")	% of Total Work Performed
6	Major Surgery, which shall be defined as:		
6-a	Orthopaedic Surgery (other than orthopaedic operations on smaller joints)		
b	Neuro-Surgery		
c	Amputation of Limbs		
d	Plating, pinning open reduction of fractures		
e	Procedures involving entry surgically or otherwise into the spine, thorax or skull		
f	Procedures involving entry surgically or otherwise in the abdomen (other than procedures concerned with normal delivery which may include episiotomy and application of low forceps).		
g	Mastectomy		
h	Resection of facila bones and tissues		
i	Operations on the organs of the neck (other than biopsy excision of lymph nodes		
j	Reconstructive vascular surgery and thromboembolectomy of the larger arteries and veins		
k	Opthalmic Surgery		
l	Mastoidectomy		
m	Operations on the inner ear		
n	Oesophagoscopy		
o	Exchange Transfusions		
7	Intermediate Surgery which shall be defined as:		
a	Tonsillectomy		
b	Adenoidectomy		
c	Closed reduction of fractures		
d	Surgical or injection treatment of varicose veins		
e	Orthopaedic operations on the smaller joints		
f	Amputation of digits		
g	Dilation and curettage		
h	Culdoscopy		
i	Cystoscopy		
j	Gastroscopy		
k	Sigmoidoscopy		
l	Bronchoscopy		
m	Biopsy excision of lymph nodes		
n	Circumcision		
8	General practice which in no circumstances includes any of the procedures in (7) above.		
9	Any other procedure (please describe)		

N.B.: Coverage is afforded only in respect of the procedures listed in (7) above for which a specific premium has been paid and in addition for General Practice. If coverage is required for any other procedures, such procedures must be specifically declared.

10. Have you or any of your Partners, Assistants, Technicians or Nurses any physical, physiological, emotional, pathologic of psychiatric disability? Yes: ☐ No: ☐

If YES, please give details; _____

11. Are you engaged in any additional medical activities for which you receive payment? Yes: ☐ No: ☐
If YES, please give details;

12. Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered? Yes: ☐ No: ☐
If YES, please give details;

13. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offences? Yes: ☐ No: ☐
If YES, please give details;

14. Have you ever been the subject of disciplinary proceedings or reprimand by an administrative body or a professional association? Yes: ☐ No: ☐
If YES, please give details;

15. Please state amount of Insurance required:

Maximum: KShs. _____ Inclusive of costs and expenses.

KShs. _____ Any one patient.

16. **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;

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

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

DECLARATION:

I/We hereby declare that the above statements and particulars are true and complete, that at the present time, other than as stated, I/We have no reason to anticipate any claim under the insurance now being requested. 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.

NB:

IF THIS PROPOSAL IS BEING COMPLETED FOR THE RENEWAL OF AN EXISTING POLICY, PLEASE REMEMBER COVER LAPSES AUTOMATICALLY AT MIDNIGHT ON THE LAST DAY OF YOUR EXPIRING POLICY, UNLESS A WRITTEN EXTENSION NO LONGER THAN 10 DAYS IS REQUESTED AND HAS BEE GRANTED FROM INSURERS, OR RENEWAL TERMS HAVE BEEN ACCEPTED.