MEDICAL MALPRACTICE
HOSPITALS, CLINICS & DOCTORS

PROPOSAL FORM

INSTRUCTIONS

Please:
1. Print clearly or type
2. ANSWER ALL QUESTIONS COMPLETELY
3. 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.
4. The form must be signed and dated by a Partner or Principal of the firm.

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 judgment 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 materials, disclose them. FAILURE TO DISCLOSE could prejudice your rights to recover in the event of a claim or allow underwriters to void the Policy.

I. GENERAL DATA

1.	Full name of institution (hereinafter referred to as "the proposer"	……………………………………………………………… ……………………………………………………………… ………………………………………………………………
2.	Business address	……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ………………………………………………………………
3.	Date of establishment	……………………………………………………………… ………………………………………………………………
4.	Is the proposer: **a.** approved by a public authority? Name of the authority and date of approval	**YES** ☐ **NO** ☐
	b. a member of the hospital association? Name of the association and date of acceptance	**YES** ☐ **NO** ☐
5.	Is the proposer maintained in whole or in part by public or private funds or endowment? Please specify.	**YES** ☐ **NO** ☐

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

1. Brief description of the proposer's activities
(e.g. operations of a hospital, nursing home, sanatorium)

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2. Estimated gross annual income
(please indicate currency) ____________________

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3. Number of patients per year — Numbers

a. In-patients ____________________

b. Out-patients ____________________

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4. Approximate division of patients between

a.	General	%
b.	Surgical	%
c.	Gynecological and obstetrical	%
d.	Pediatric	%
e.	Orthopedic	%
f.	Dental	%
g.	Psychiatric	%
h.	Any other classes	%
	____________________	%
	____________________	%
	____________________	%

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5. Number of employed doctors (including doctors in clinics)
in each of the following classifications

a.	Surgeons	____________
b.	Cosmetic surgeons	____________
c.	Anesthetists	____________
d.	Gynecologists	____________
e.	Internal specialists	____________
f.	Urologists	____________
g.	Orthopedists	____________
h.	Radiologists	____________
i.	Ophthalmologists	____________
j.	Dentists	____________
k.	Physicians	____________
l.	Interns (licensed and unlicensed)	____________
m.	Others (please specify)	____________

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6. Medical assistants (pharmacists, laboratory technicians, etc.) — Numbers

7. Number of nurses
a. Graduates ____________
b. Undergraduates or students ____________

8. Number of beds (including for maternity cases) ____________

9. Does the proposer own or operate X-ray machines, lasers, ultrasound machines or similar equipment? **YES** ☐ **NO** ☐

If so, please specify and give number of machines, type and whether they are used for diagnosis or treatment or both.

10. Does the proposer use radioactive materials? **YES** ☐ **NO** ☐

If so, please specify machinery &/or materials used.

11. Does the proposer operate a blood bank? **YES** ☐ **NO** ☐

If so, please advise percentage of use
a. For own purpose ____________ %
b. For supply to other parties ____________ %

III. PREVIOUS INSURANCE / PREVIOUS CLAIMS

1. Has the proposer previously been insured? **YES** ☐ **NO** ☐
If so, please specify:

	Name of Insurer	Policy period	Limit of indemnity
1.			
2.			
3.			
4.			
5.			

2. Has a previous application been declined? **YES** ☐ **NO** ☐

Has a previous insurance

a. required increased premium? **YES** ☐ **NO** ☐

b. required special restrictions? **YES** ☐ **NO** ☐

c. been terminated/not been renewed by an insurer? **YES** ☐ **NO** ☐

If so, please give detailed information

3. Have any claims or suits for malpractice been made during the past five years against the proposer? **YES** ☐ **NO** ☐

If so, please advise amount and background of each claim.

4. Is the proposer aware of any circumstances or incidents which may result in a claim or claims against him? **YES** ☐ **NO** ☐

If so, please give details.

IV. INDEMNITY REQUIRED

1. Limit any one claim

2. Limit in the annual aggregate

3. Deductible each and every claim to be borne by insured

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.

Signing this proposal form does not bind the proposer or underwriter to complete this insurance.

Dated this day of 20

For and on behalf of ____
(insert name of firm)

Signature of partner or principal ____________________________________

Please attach a brochure concerning your firm.