

QBE MEDICAL MALPRACTICE Insurance Proposal Form for Miscellaneous Medical Risks



QBE Insurance (Malaysia) Berhad Registration No: 198701002415

(Part of QBE Insurance Group)

(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

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IMPORTANT NOTICES

- Pursuant to Paragraph 4(1) of Schedule 9 of the Financial Services Act 2013, if you are applying for this insurance for a purpose related to your trade, business or profession, you have a duty to disclose any matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance.
- The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.
- You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in this Proposal Form is inaccurate or has changed.

QBE Agency No.:

QBE Agency Name:

PERIOD OF INSURANCE

From

To

(dd/mm/yyyy)

A. PARTICULAR OF PROPOSER

Salutation:

Mr

Ms

Miss

Others (please specify)

Name of Proposer

Correspondence Address

Postcode

City

State

Country

Contact Number

Email

Occupation (if more than one please state all)

1. Personal Details (For Consumer Contract)

Gender

Male

Female

Marital Status

Married

Single

Divorced/ Widowed

Identification Number

New NRIC

Passport

Military IC

Others

Handphone Number

Nationality

Date of Birth

(dd/mm/yyyy)

Tax Identification No.

2. Business Details (For Non-Consumer Contract)

Tax Identification No.

Business Registration No.

SST Registration No.

Tel No. (Office)

Trade or profession or nature of business

How long has the business been established?

Clear 1

B. DETAILS OF APPLICANT

1. Full name of all entities to be insured (including service, administrative or nominee companies and subsidiaries that you wish to be covered by this policy):
(Hereinafter the applicant will be referred to as "You" or "Your")

2. Your Principal Address

3. Address(es) of branch offices or other locations

4. Date on which the Practice was established

(dd/mm/yyyy)

5. Please supply the following details:

Names of Partners, Principals and Directors	Age	Qualifications	Date Qualified	Period Practicing as Partner, Principal or Director	
				This Practice	Previous Practice

6. Please supply total numbers of:

(a) Partners/principals/directors

(e) Non-technical administrative staff

(b) Qualified Staff

(f) Clerical staff

(c) Other technical staff

(g) Other staff (please specify)

(d) Trainee staff

TOTAL OF ALL STAFF

For Sole Proprietors Only - Questions 7. and 8.

7. State the experience of your assistants and their length of service.

8. What arrangements do you have to assist you during your temporary absence on business, leave, sickness, or unforeseen emergency?

C. DETAILS OF PRACTICE

1.1 Has the name of the practice ever been changed?

Yes

No

1.2 Has any other practice or business amalgamated or merged with you?

Yes

No

1.3 Have you purchased any other practice or business?

Yes

No

If you have answered YES to either part B.1.1.1, B.1.1.2 or B.1.1.3, please supply details.

C. DETAILS OF PRACTICE (Continuation)

2. Is any partner, principal or director connected or associated (financially or otherwise) with any other practice or business? Yes No

If you have answered YES please supply details.

3. Please list the professional bodies or associations to which the Applicant belongs.

4. Please detail the approximate percentage of your fee income derived from the following fields of work:

Type of Work		Type of Work	
(a) Acupuncture	<input type="text" value=""/>	(l) Chiropractic	<input type="text" value=""/>
(b) Audiology / audiometrics	<input type="text" value=""/>	(m) Massage	<input type="text" value=""/>
(c) Optometry	<input type="text" value=""/>	(n) Nutrition / dietetics	<input type="text" value=""/>
(d) Beauty Therapy / aesthetics	<input type="text" value=""/>	(o) Pathology	<input type="text" value=""/>
(e) Hair and scalp treatment	<input type="text" value=""/>	(p) Clinic research	<input type="text" value=""/>
(f) Chiropody	<input type="text" value=""/>	(q) Physiotherapy	<input type="text" value=""/>
(g) Podiatry	<input type="text" value=""/>	(r) Psychology	<input type="text" value=""/>
(h) Chemical / pharmaceutical	<input type="text" value=""/>	(s) Speech therapy	<input type="text" value=""/>
(i) Dentistry / orthodontics	<input type="text" value=""/>	(t) Occupational therapy	<input type="text" value=""/>
(j) Home nursing	<input type="text" value=""/>	(u) Naturopathy	<input type="text" value=""/>
(k) Osteopathy	<input type="text" value=""/>	(v) Other (complete question 5)	<input type="text" value=""/>



Grand total of all divisions above must come to 100%

5. Complete if applicable (refer Question 4. above)

5.1 Please provide details of the precise nature of activities or business.

5.2 Please categorise the activities or business outlined in Question 5.1 above and indicate the approximate percentage of your fee income derived from same.

	%
	%
	%
	%
	%

5.3 (a) Please provide details of advice given in relation to the activities or business outlined in Question B. (4) or (5.1) previously.

(b) Are verbal reports always confirmed in writing? Yes No

If NO, how do you substantiate such verbal reports?

Clear 3

C. DETAILS OF PRACTICE (Continuation)

6. Does any contract or client represent more than 50% of your annual work or fees? Yes No
7. Does you engage consultants, sub-contractors or agents? Yes No
 If YES
- 7.1 do you insist they carry their own professional indemnity or malpractice insurance? Yes No
- 7.2 do you enter into any hold-harmless agreements or otherwise waive any legal rights or entitlements which you may have against such consultants, sub-contractors or agents? Yes No
8. Do you envisage any substantial changes in your activities or are there any major new operations contemplated during the next 12 months? Yes No
 If yes, please supply details.

9. Do you perform work outside of Malaysia, or work for clients located overseas? Yes No
 If Yes, please supply details.

D. FINANCIAL DETAILS

1. 1.1 Please advise the date of your financial year end: (dd/mm/yyyy)
- 1.2 Please provide the amount of gross income/fees for the following
- | | Malaysia | Overseas |
|---------------------------------------|----------------------|----------------------|
| (a) current financial year (estimate) | <input type="text"/> | <input type="text"/> |
| (b) last financial year | <input type="text"/> | <input type="text"/> |
| (c) previous financial year | <input type="text"/> | <input type="text"/> |
- 1.3 Please provide the amount of the largest annual fee for any one client.

2. Please provide the approximate percentage of your activities (based on gross income) applicable to each state, territory and overseas.

Country	Malaysia	Asia	Europe	USA/Canada	Others
Percentage of income	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %

E. CLAIMS DETAILS

1. Has any partner, principal, director or staff member ever been subject to disciplinary proceedings for professional misconduct? Yes No
 If YES, please supply details.

2. Have any claims for negligence or breach of professional duty been made in the last ten (10) years against the Practice or any of their predecessors in business or any prior Practice of any of their present or former partners, principals or directors, or have circumstances been notified to insurers that might give rise to a claim? Yes No
 If YES, please supply details.

Date Matter Notified	Name of Insurer (if any)	Name of Claimant or Potential	Brief Description	Amount paid or estimate of Potential Liability	Is Matter Finalised or Outstanding

E. CLAIMS DETAILS (Continuation)

3. Are any of the Partners, principals or directors, AFTER ENQUIRY, aware of any claim or circumstances that might give rise to a claim against the Practice or any prior Practice or any of their present or former partners, principals or directors which matter is not referred to in Question D.2 above? Yes No

If YES, please provide the following details in respect to each matter.

Name of Claimant or Potential Claimant	Brief Description of the Matter	Estimate of Potential Liability

F. DETAILS OF INSURANCE COVER

1. 1.1 Does the Practice presently carry, or has the Practice ever carried, malpractice liability insurance? Yes No

If YES, please supply details.

Insurer

Expiry Date

Limit of Indemnity

Premium

1.2 Has the Practice or any partner, principal or director ever been refused this type of insurance, or had similar insurance cancelled, or had an application of renewal declined, or had special terms imposed? Yes No

If YES, please supply details

G. APPLICATION FOR COVER

1. 1.1 Limit of indemnity required

1.2 Deductible/Excess requested (each and every claim)

1.3 Extensions:

(i) Automatic Extensions

- √ Libel and slander Automatically Included
- √ Loss of documents Automatically Included
- √ Coroner's enquiries Automatically Included
- √ Emergency first aid Automatically Included
- √ Students Automatically Included
- √ Newly created or acquired entity or subsidiary Automatically Included
- √ Run-off cover insured entity or subsidiary Automatically Included
- √ Estates and legal representatives Automatically Included

H. DECLARATION & CONSENT

I/we hereby declare that I/we have fully and accurately answered the questions in this proposal form.

Privacy Statement - I understand that the personal data provided to purchase the above insurance will be used by QBE Insurance (Malaysia) Berhad to facilitate the performance of the function as an insurance company. I allow QBE Insurance (Malaysia) Berhad to collect, use and disclose my personal data to selected third parties in or outside Malaysia, in accordance with Privacy Policy Statement which is posted at our website www.qbe.com/my.

I/We further that the QBE Insurance (Malaysia) Berhad and/or it's holding company can share and use my/our data and personal information for the purpose of promoting the Company's and/or it's holding company's products, new services and support requirement, and marketing campaigns and activities and commercial transitions.

The liability of the Company does not commence until the application has been accepted.

Proposer's signature &
Company stamp

Date

(dd/mm/yyyy)

I. DECLARATION BY AGENT / BROKER / OFFICER (STAFF OF INSURANCE COMPANY)

1) In compliance with the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001, I hereby certify that the Applicant's original NRIC/Passport/Business Registration Certificate was verified and authenticated by me at the point of sales.

2) I/We have recommended this product being purchased by the proposer, based on the information disclosed and other relevant information which are made available to me/us. I/We have taken reasonable steps to ensure the advice is suitable to the customer for the purpose of insurance coverage.

Name

NRIC No.

Signature &
Company Stamp

Date

(dd/mm/yyyy)