

QBE MEDICAL MALPRACTICE Insurance Proposal Form for Miscellaneous Medical Risks



QBE Insurance (Malaysia) Berhad Reg. No.: 198701002415 (161086-D)

(Part of QBE Insurance Group)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)
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Your Duty of Disclosure:

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for purposes unrelated to your trade, business or profession, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in this Proposal Form. You must answer the questions in this Proposal Form fully and accurately.

Failure to take reasonable care in answering the questions 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.

In addition to answering the questions in this Proposal Form, you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

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.

Please complete information in full and check boxes tick (✓) where appropriate. Please answer on a separate sheet of paper if the space provided is insufficient.

Cover Note No.	<input type="text"/>	Intermediary No.	<input type="text"/>
Intermediary Contact Number	<input type="text"/>	Intermediary Name	<input type="text"/>
Name of Company	<input type="text"/> (Hereinafter referred to as "Company" in this Proposal and in the Policy)		
Principal Address	<input type="text"/> <input type="text"/>		
Postal Code	<input type="text"/>	Contact no	<input type="text"/>

A. 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)

A. DETAILS OF APPLICANT (Continuation)

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	<input type="text"/>	(e) Non-technical administrative staff	<input type="text"/>
(b) Qualified Staff	<input type="text"/>	(f) Clerical staff	<input type="text"/>
(c) Other technical staff	<input type="text"/>	(g) Other staff (please specify)	<input type="text"/>
(d) Trainee staff	<input type="text"/>	TOTAL OF ALL STAFF	<input type="text"/>

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?

B. DETAILS OF PRACTICE

- 1. 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.

- 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.

B. DETAILS OF PRACTICE (Continuation)

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



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.

<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %
<input type="text"/>	<input type="text"/> %

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?

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

Clear 3

B. DETAILS OF PRACTICE (Continuation)

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.

C. 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"/> % |

D. 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, principles 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 |
|----------------------|--------------------------|-------------------------------|-------------------|--|------------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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 |
|--|---------------------------------|---------------------------------|
| | | |
| | | |
| | | |
| | | |

E. 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

F. 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 |

G. 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.

Proposer's Signature

Date: (dd/mm/yyyy)

H. DECLARATION BY AGENT / BROKER / OFFICER (STAFF OF QBE)

In compliance with Section 16(2) of the ANTI-MONEY LAUNDERING AND ANTI-TERRORISM FINANCING (AMENDMENT) ACT 2014

1. I/ WE hereby certify that I have verified and authenticated the Proposer's NRIC / Business Registration Certificate at the point of sales.
2. I/WE have maintained a copy of the NRIC of the applicants of individual insurance where premium is more than RM50,000.00, a copy of Certificate of Incorporation (ROC or ROS) for applicants of group insurance policies where premium is more than RM100,000.00.

Name

NRIC No

Signature &
Company Stamp:

Date: (dd/mm/yyyy)