IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

PROFESSIONAL INDEMNITY POLICY
UIN: IRDAN106RP0044V01202223

PROPOSAL FORM - APPLICABLE FOR
MEDICAL ESTABLISHMENTS

This proposal must be signed. All questions must be answered. The completion and signature of this proposal does not bind the proposer or Insurer to complete a contract of Insurance.

If there is insufficient space to answer questions, please use additional sheets and attach it to this form.

The Company doest not assume any liabilities until the Proposal has been accepted and premium paid.

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1) Name and Address of Proposer:

2) When established:

3) Full details of work carried on
(Please attach brochure, information booklet, etc.
if any & specimen copy of contracts
entered into)

4) a)

Names in full of all Partners/Directors/ Principals	Qualifications in full	Date qualified	How long principal in this practice

b) Is coverage required in respect of past work for any Partner/Principal who has left, retired or died? YES/NO.
If 'YES' please give the following

Full Name	Qualifications	How long Principal in this practice

5) a) Is the Establishment registered with the local competent authority ? If No, why ?

b) Have you complied with all statutory rules / regulations relating to your establishment ?

6) i) Are the Doctors / Technicians working for you

a) duly licensed in accordance with the Medical Acts or any other prevalent laws

b) Members of Medical Association Council

ii) Do you employ only qualified Nurses?

7) State the number of employees and visiting practioners in each of the following classifications:

General Physicians

Specialists including surgeons in different disciplines.

- Eye / ENT
- Pathologists
- Cardiologists
- Radiologists
- Plastic Surgeons
- Dentist
- Pharmacists
- Technicians
- Nurse
- Trainees
- Other (Please specify)

8) a) Please specify all the facilities available like x – rat, Scanning, Pathology, etc.

b) Whether persons operating these are qualified to operating these are qualified and will experienced

c) Do you with to extend the policy to cover the personnel who are not professionally qualified to operate the facility assigned to them?

If yes, please give names of the personnel and the facility operated.

d) Is the establishment under care of qualified doctor round the clock?

e) Is a qualified nurse in attendance round the clock?

9) a) Please state the no. of Beds including bassinettes maintained by you.

b) State no of fully equipped operation theatres

10) Do you have an out – patients department? Please specify:

a) No. of patients actually treated in the previous year

b) No. of patients estimated to be treated in the proposed year

11) Please state the following particulars regarding the in – patients treated

	Projected year	Current Year	Previous year
a) General	_____	_____	_____
b) Medical	_____	_____	_____
c) Surgical	_____	_____	_____
Total:	_____	_____	_____

12) Give details of radioactive treatment facility. Specify the materials under and precautions taken for such usage

13) Whether food is supplied by you to patients ? If yes, specify whether it is prepared by you or contractors. Please specify the measures taken for maintenance of kitchen and other supervisory measures

14) State estimated annuli income includes room charges Operation Theater, Rent, charges or X- ray facilities, doctor's fees nursing charges, medicines, food , surcharge and any other income

15) Loss record for 5 years:

Year	Cause	Kind of Loss	Amount of Loss
20___			
20___			

16) Have you during the past 12 months dismissed or do you contemplate dismissal of any member of staff on account of any omission, neglect, error or for like (please give full details)

17) Are you aware of any neglect, omission or error or existence of any circumstances likely to give rise to a claim?

	Year	Fee
18) (a) Annual fees earned during the last five years expected revenue		
(b) Estimated fees for the current year 20____		

19) Previous Insurance History

20) Limits of Indemnity required: Any One Act : Rs.
Any One Year : Rs.

21) Voluntary Excess

22) Period of Insurance Required From _____ To _____

I/We hereby declare that the above statement and particulars are true and I/We have not suppressed or misstated any material facts and that at the present time I/We have no reason to anticipate any claim being brought against me/us for any negligent act, error or omission on my/our part and against the company and agree that this declaration shall be the basis of the contract between me/us and the Insurer. I/We also agree that the indemnity under the insurance shall not be availed for claims arising out of acts of negligence, error or omission or misconduct

committed PRIOR to commencement of this Insurance. I/We declare that all statutory requirements relating to our profession/ business activities have been complied by us.

SIGNATURE OF PROPOSER

Date :

Place:

SECTION 41 OF THE INSURANCE ACT, 1938

PROHIBITION OF REBATES

1. No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the prospectus or tables of the Insurer.

2. Any person making default in complying with the provisions of this Section shall be punishable with fine which may extend to Rs. 10,00,000/-.