QBE MEDICAL MALPRACTICE Insurance Proposal Form
for Medical Establishments

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. | **Intermediary No.**

Intermediary Contact Number | **Intermediary Name**

Name of Company

(Hereinafter referred to as "Company" in this Proposal and in the Policy)

Principal Address

Postal Code | **Contact no**

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. **Full name of owner**
3. **Principal address of Establishment**
4. **Address(es) of branch offices or other locations**
5. **How long has the Establishment been operated by the present owners?**

Clear 1

A. DETAILS OF APPLICANT (Continuation)

6. Please supply the following details:

Title of Staff Member	Name	Age	Qualifications	Date Qualified
Chief executive officer				
General manager				
Director of medical services				
Director of allied health services				
Director of nursing				

7. Is the Establishment duly licensed to practice at the address(es) specified in Question 3 and 4? ☐ Yes ☐ No

8. Please provide total numbers of employees in each of the following classifications:

(a) Surgeons		(f) Pharmacists	
(b) Doctors		(g) Registered nurses	
(c) Interns		(h) Enrolled nurses	
(d) X-ray technicians		(i) Undergraduate of student staff	
(e) Laboratory technicians		(j) Other medical or allied health employees	
		TOTAL	0

B. DETAILS OF ESTABLISHMENT

1. 1.1 Has the name of the Establishment ever been changed? ☐ Yes ☐ No

   1.2 Has any other establishment amalgamated or merged with you? ☐ Yes ☐ No

   1.3 Have you purchased any other establishment? ☐ 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. Please list the professional bodies or associations to which the Establishment belongs.

3. Does the Establishment have:

   (a) an intensive care unit? ☐ Yes ☐ No

   (b) a casualty or outpatients department? ☐ Yes ☐ No

   (c) a radiotherapy unit? ☐ Yes ☐ No

   (d) a medical teaching facility? ☐ Yes ☐ No

4. Does the Establishment operate any training school? ☐ Yes ☐ No

   If YES, please supply details.

5. Do you maintain accurate descriptive records of all medical services rendered? ☐ Yes ☐ No

6. Do you ensure that all doctors of medicine (whether employed or visiting) who provide medical services for, or use the facilities of, the Establishment are members of a recognised medical defence union/association or protection society, or otherwise carry their own malpractice liability insurance covers? ☐ Yes ☐ No

Clear 2

B. DETAILS OF ESTABLISHMENT (Continuation)

7. Is there a blood banking facility? ☐ Yes ☐ No

If YES, please provide the following details.

(a) (i) percentage of blood bought ____ %

(ii) percentage of blood collected ____ %

(b) (i) approximate number of litres per annum ____

(ii) approximate number of plasmapheresis procedures carried out per annum ____

(iii) estimated annual gross receipts from the sale of the following per annum:

whole blood RM ____

blood plasma RM ____

serum RM ____

other blood products or derivatives RM ____

(c) Please provide details of:

(i) the screening procedure of persons from whom blood or plasma is drawn.

____

____

(ii) the screening procedure of the products identified in Question 7(b)(iii) prior to their sale, use or disposal.

____

____

8. Please provide the approximate division of your patients between:

(a) General medical	%	(i) Alcohol & other drugs	%
(b) Surgical	%	(j) Obstetrics / maternity	%
(c) Oncology	%	(k) Neo-natal	%
(d) Tubercular / communicable	%	(l) Elective cosmetic	%
(e) AIDS / HIV	%	(m) Elective terminations	%
(f) Senile or aged	%	(n) Paediatric	%
(g) Palliative	%	(o) Allied health therapy	%
(h) Mental health	%	(p) Other (please specify)	%

Grand total of all divisions above must come to 100%

9. Please provide (A) the number of beds maintained by the Establishment (including day surgery beds) ____

(B) The number of bassinets ____

10. Please provide the approximate annual occupancy rate for the last financial year ____ %

11. Please advise number of (A) Out Patients and (B) Admitted in Patients, during last financial year (A) ____

(B) ____

Clear 3

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

   (a) current financial year (estimate)

   (b) last financial year

   (c) previous financial year

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	%	%	%	%	%

D. CLAIMS DETAILS

1. Has any Employee of the Establishment ever been subject to disciplinary proceedings for professional misconduct? ☐ Yes ☐ No

   If YES, please supply details.

2. Have any claims for malpractice been made in the last ten (10) years against the Establishment 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. Is the Applicant, AFTER ENQUIRY, aware of any claim or circumstances that might give rise to a claim against the Establishment 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 Establishment presently carry, or has the Establishment ever carried, malpractice liability insurance? ☐ Yes ☐ No

   If YES, please supply details.

   Insurer

   Expiry Date

   Limit of Indemnity

   Premium

   1.2 Has the Establishment 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

Clear 4

F. RISK MANAGEMENT

1. Do you have and follow documented risk management and quality control procedures? ☐ Yes ☐ No
2. Are these risk management procedures regularly reviewed and updated to the appropriate standards applying to your industry? ☐ Yes ☐ No
3. Are all appropriate staff members familiar with these procedures and/or standards? ☐ Yes ☐ No
4. Do you and your staff attend regular continuing education programmes that are by your Professional Association or industry bodies or groups? ☐ Yes ☐ No

Please provide a separate written comment to explain why a "No" answer was provided.

5. What procedures do you have for the reporting of medical incidents? Please provide full 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.

Proposer's Signature

Date: (dd/mm/yyyy)

Clear 5

I. 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)**	

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