BERJAYA SOMPO INSURANCE

Proposal Form

Medical Malpractice Liability Insurance-Hospitals

A copy of the **Product Disclosure Sheet (PDS)** is available at our Customer Service Centre, branch offices or our intermediaries. Please make sure that you have read and understood the contents of the **PDS** before purchasing the product.

Berjaya Sompo Insurance Berhad (Registration No. 198001008821 (62605-U)) (BSIB) is licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia.

Berjaya Sompo Insurance Berhad is a member of Perbadanan Insurans Deposit Malaysia (PIDM). For more information, kindly contact PIDM at 1-800-88-1266 or visit the PIDM website at www.pidm.gov.my.

IMPORTANT NOTICE ON PRE-CONTRACTUAL DISCLOSURE AND REPRESENTATION

Non-Consumer Insurance Contract
Pursuant to Schedule 9 of the Financial Services Act 2013, if you are applying for this insurance for purposes of your trade, business or profession, you have a duty to disclose any matter you know to be relevant to our decision in accepting the risks and determining the rates and terms of your insurance. You also have a duty to inform us of any change in the details or information given to us before we issue the Policy to you, or before you renew or change any of the terms of your Policy. If you fail to do so, your Policy may be cancelled or treated as if it never existed, or your claim may be rejected or not fully paid.

The above duty of disclosure for Non-Consumer Insurance Contract 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 READ THE FOLLOWING NOTE BEFORE YOU COMPLETE THE PROPOSAL

1. **CLAIMS MADE POLICY**
   THE TERMS AND CONDITIONS of a Claims Made Policy provide that, if a claim is made against you or any notice of an intention to make a claim against you is received or circumstances come to your attention which are likely to cause a claim to be made against you or which you should reasonable expect to cause a claim to be made against you during the term of the Policy then you must immediately notify Underwriters thereof. This notification must be given during the term of the Policy for the Policy to apply.

   The time of happening of the acts or circumstances which give rise to a claim or possible claim is not of relevance provided they occur after the retroactive date stated on the Certificate of Insurance and the relevant sum insured is adequate. Your obligation under the Policy is to communicate to Underwriters during the term of the Policy a claim, notice of a possible claim or circumstance or act which comes to your attention and which may give rise to a claim or which you should reasonably expect may give rise to a claim as soon as is reasonably possible after such is made, received or has come to your attention.

   Upon expiry of the Policy no further claims can be made thereunder and the need to maintain insurance or to arrange run off coverage is essential.

2. **UTMOST GOOD FAITH**
   This Insurance is a contract based on the utmost good faith requiring the Insurer(s) and the Proposer / Insured(s) to act towards each other with the utmost good faith in respect of any matter arising in relation to this insurance.

IMPORTANT

1. Please answer all questions, leaving no blank spaces.
2. If you have insufficient space to complete any of your answers, please continue on your headed paper.
3. This form must be signed and dated by a Partner, Principal or Identified Officer of the Firm.
4. If you have a brochure about your firm's operation(s), please forward a copy with this application.
5. If the firm is a body corporate, "Partners" is deemed to read "Directors".

Please use BLOCK letters and CROSS (X) in appropriate box

PARTICULARS OF PROPOSER	
1. (a) Full name of Hospital, etc. (Hereinafter referred to as "The Proposer") (b) How long being operated by present management? (c) Business Registration Number/NRIC No:	
2. Address/es of Premises.	
3. Does the Proposer provide any medical services at the premises other than address stated in the Ques-tion 2 above? If so, please state the address.	
4. Name(s) of Owner(s) or Partners, and details of experience/qualifications.	
5. Is the Proposer maintained in whole, or in part, by public or private funds or endowment?	
6. Does the Proposer act as a Charitable Institution? If so, please state percentage of full charity patients:	
7. Is the Proposer duly licensed in accordance with law to practice at the address (es) specified in the answer to Question 2?	
8. Please give brief description of Proposer's activities :	
9. Please state approximate division of your patients between: (a) General _____ (b) Medical _____ (c) Surgical _____ i. Elective Cosmetic ii. Organ Transplant iii. Others (d) Maternity / Obstetric _____ (e) Communicable Diseases_____ (f) Geriatric _____ (g) Psychiatric _____ (h) Drug / Alcoholics Dependency ___ (i) Any other classes _____	(a) _____ % (b) _____ % (c) i._____ % ii. _____ % iii. _____ % (d) _____ % (e) _____ % (f) _____ % (g) _____ % (h) _____ % (i) _____ %

10. Please state number of Medical staff in each of the following classifications: (a) Non-procedural Physicians : i. Psychiatrists ii. Others (b) Surgeons : i. Cosmetic ii. Orthopedic iii. Others (c) Anesthetists_____ (d) Obstetricians _____ (e) Gynecologists._____ (f) Dentists_____ (g) Lab / Path Technicians _____ (h) Pharmacists_____ (i) Paramedics (j) Midwives (k) Registered Nurses : i. Day ii. Night (l) Undergraduate / Student Nurses : i. Day ii. Night (m) Enrolled Nurses : i. Day ii. Night (n) Others (please specify) : i._____ ii. _____	Employees (a) i._____ ii._____ (b) i. _____ ii. _____ iii. _____ (c) _____ (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) i. _____ ii._____ (l) i._____ ii._____ (m) i. _____ ii._____ (n) i. _____ ii. _____	Non-Employees (a) i._____ ii._____ (b) i. _____ ii. _____ iii. _____ (c) _____ (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) i. _____ ii._____ (l) i._____ ii._____ (m) i._____ ii._____ (n) i. _____ ii. _____
11. Does the Proposer have management procedures designed to locate and remove from patient contact any Insured person or employee infected by contagious disease? If NO, how the Proposer can avoid patient con-tact with Insured person or employee infected by contagious disease?	☐ Yes ☐ No	
12. Does the Proposer ensure that all qualified medical practitioner (whether employed or visiting) who provide medical services for, or use the facilities of the Proposer are members of a recognized medical defense union/association or protection society, or otherwise carry their own malpractice liability in-surance covers? Please note that this policy is designed to cover claims made against the Proposer. If cover is also required for claims made against past or present registered medical practitioners or den-tists (whether employed or visiting) for work per-formed at the premises of the Proposer, please supply a list of all doctors/dentists for whom coverage is required stating the Name, Date of Birth, Qualifications and Practice of each doctor /dentist.	☐ Yes ☐ No	

13. Does the Proposer give radium or other radio-active treatment? If so, please give details stating by whom treatment is given.	☐ Yes ☐ No
14. Does the Proposer render treatment / services to provoke / avoid gravidity / procreation, including operations to produce sterility, in-vitro-fertilization and/or abortions? If YES, please give details stating whether visit-ing doctor or employee render treatment / service and number of patients treated in the last 12 months.	☐ Yes ☐ No
15. Does the Proposer render treatment / services for weight reduction? If YES, please give details stating whether drugs are used and number of patients was treated in the last 12 months.	☐ Yes ☐ No
16. Does the Proposer undertake clinical trials of any kind? If YES, please give details :	☐ Yes ☐ No
17. Does the Proposer operate Accident & Emergen-cy (A&E) Department?	☐ Yes ☐ No
18. Does the Proposer run ambulance services? *This insurance does not cover claims arising out of delay in transportation or interruption of am-bulance services.	☐ Yes ☐ No
19. (a) Please state total number of beds maintained (b) Number of patients in last year	Beds _____ Bassinets / Cribs / Cots _____ In-patients _____ Out-patients _____ Babies delivered _____
20. Are Clinics maintained? If so, state: (a) Kind _____ (b) Whether free, part-pay or full-pay _____ (c) Number of: i) Employed Clinic Physicians & Dentist _____ ii) Nurses _____ iii) Patients per year _____	(a) _____ (b) _____ (c) i. _____ ii. _____ iii. _____
21. (a) Estimated Gross Annual Income for next 12 months (b) Actual Gross Annual Income for past 12 months	(a) RM_____ (b) RM_____

22. Has the Proposer any other Professional Indemnity, Malpractice or Public Liability Insurance? If so, please give details. i. Name of Insurer ii. Limit of Indemnity iii. Excess / Deductibles iv. Expiry Date	☐ Yes ☐ No i. _____ ii. _____ iii. _____ iv. _____
23. Has any Insurance Company ever cancelled, de-clined, refused to renew or only accepted on special terms the proposer's Professional Indemnity, Mal-practice or Public Liability Insurance? If so, please give details :	
24. Have any claims or suits for Malpractice or Negligence been made against the Proposer or is the Proposer aware of any circumstances which may result in any such claims being made against the Proposer? If so, please give details :	
25. (a) Limit of Indemnity required_____ (b) The self-insured Excess you are prepared to carry in respect of each and every claims _____	i. RM_____ ii.RM_____ iii.RM_____ RM_____
26. Does the firm require indemnity for any or all of the following extensions for which extra premium may be required? (a) Amendment to the dishonesty exclusion (fraud and dishonesty of staff)_____ (b) Automatic Reinstatement of limited of indemnity_____	☐ Yes ☐ No ☐ Yes ☐ No
27. Is there any further information that should be made known to Underwriters so that they may form a proper estimate of the risk?	

PAYMENT METHOD

Total Premium Paid: RM ..... Please select payment method.

☐ Cash

☐ JomPay For payment via JomPay, please provide proof of payment.

Biller Code: 1388
Ref-1: Cover note No/Policy No/EndtNo
Ref-2: Agent Code/Name & Contact No

JomPAY online at Internet and Mobile Banking with your Current, Savings or Credit Card account

☐ Visa
☐ MasterCard

Card No. ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ Expiry Date m m / y y

Cardholder's Name: .....

Date: ..... Cardholder's Signature: .....

SERVICE TAX - The Premium payable by you shall be subjected to service tax pursuant to the Service Tax Act 2018, including any subsidiary legislations, orders or regulations governing the application of such tax, as may be imposed or amended by the relevant authorities from time to time.

PRIVACY NOTICE

The Personal Data provided by and collected from you may be used and processed by us in order for us to provide our services in accordance with our Privacy Notice, which explains how we treat your Personal Data. Please refer to our Privacy Notice which is available on our website at www.berjayasompo.com.my for details. You may contact us for access to or correction of your Personal Data, or for any other queries or feedback.

ACKNOWLEDGEMENT

I/We acknowledge that the answers/information provided in this proposal form are true and correct and I/we have not withheld any information or made any misrepresentation likely to affect the acceptance of this proposal. I/We shall undertake to notify the Company when there is any subsequent change to the information provided in this proposal form. I/We understand and acknowledge receipt of a copy of the **Product Disclosure Sheet (PDS)** which has/have been made available to me/us. I/We acknowledge that the key contract terms have been adequately explained to me/us and I/we fully understand the terms.

Date ..... Proposer's Signature .....
(If the Proposer is a company, authorised signature(s) and chop)

FOR AGENT / OFFICE USE

Cover Note / Policy No.:

Intermediary:

Account No.:

Remarks: