BERJAYA SOMPO INSURANCE

Proposal Form

Medical Malpractice Liability Insurance

(This proposal does not apply to hospitals or special schools)

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

Claims made insurance only covers claims made against you during the period of insurance. However, provided you give the insurers notice in writing of any facts that might give rise to a claim against you, as soon as reasonably practicable after you became aware of those facts and before the expiry date of this insurance then this insurance will respond notwithstanding the fact that no claim has actually been made against you prior to the expiry date.

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 an executive director or senior officer of the Proposer
4. If you have a brochure about your operation(s), please forward a copy with this application.

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

PARTICULARS OF PROPOSER	
1. i) Full name of service unit(s) where medical service is provided. (Hereinafter referred to as "The Proposer") ii) How long operated by present management? iii) Legal entity running the medical service iv) Business Registration Number/NRIC No	
2. Address/es of Premises where medical services are provided	
3. Is the Proposer duly licensed in accordance with law to practice at the address(es) specified in the answer to Question 2?	
4. Has the Proposer have any other Professional Indemnity, Malpractice &/or Public Liability Insurance? If so, give details.	
5. Has any Insurance Company ever cancelled, declined, refused to renew or only accepted on special terms the proposer's Professional Indemnity, Malpractice or Public Liability Insurance. If so, give details.	
6. 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:	
7 (a) Limit of Indemnity required (b) The self-insured Excess you are prepared to carry in respect of each and every claims	(a) RM _____ (b) RM _____
8. Does the Proposer 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	☐ Yes ☐ No ☐ Yes ☐ No
9. Give brief description of Proposer's medical / healthcare services provided	
10. State approximate division of your patients between: (a) General _____ (b) Medical _____ (c) Surgical _____ (d) Tubercular _____ (e) Communicable _____ (f) Senile or Aged _____ (g) Insane _____ (h) Drug Addicts _____ (i) Alcoholics _____ (j) Any other classes _____	(a) _____ % (b) _____ % (c) _____ % (d) _____ % (e) _____ % (f) _____ % (g) _____ % (h) _____ % (i) _____ %

11. State number of beds maintained in the following categories: (a) hostel for the elderly (b) homes for the aged (c) care and attention home (d) nursing home (e) halfway houses (f) Others	
12. State the number of clients/ out-patients annually (a) day care centres (b) enhanced home care and community services (c) dental clinic (d) medical clinic (e) Chinese medicine clinic (f) clinical psychology service (g) Others	
13. (a) Estimated Gross Annual Income for the unit (subvention + donations + service fee income) for next 12 months (b) Actual Gross Annual Income for the unit (subvention + donations + service fee income) for past 12 months	(a) RM _____ (b) RM _____
14. State number of employees in each of the following classifications: (a) Doctors, Dentists (b) Nurses: i. Registered Nurses ii Undergraduate or Student Nurses (c) Clinical psychologists (d) Speech therapists (e) Occupational therapists (f) Physiotherapists (g) Other para-medical workers (h) Chinese medicine practitioners i. General practitioner ii. Specialist (acupuncture) iii. Specialist (orthopaedic)	(a) (b) i. _____ ii. _____ (c) (d) (e) (f) (g) (h) i. _____ ii_____ iii_____
15. State number and classes of Non-employed medical workers working on your behalf e.g. locum, volunteers, secondees	
16. 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 insurance covers? **Please note that this policy is designed to cover claims made against the Proposer.** If cover is also required for claims made against registered medical practitioners or dentists (whether employed or visiting) for work performed 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

17. Do all the premises comply with all necessary fire regulations?	
18. Do the premises comply with the current regulations of the Hospitals, clinics, elderly homes and equivalent legislation regulated by government authorities?	
19. 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: