MEDGULF
THE MEDITERRANEAN & GULF COOPERATIVE INSURANCE & REINSURANCE CO. (S.J.S.C)
ميدغلف
شركة المتوسط والخليج للتأمين وإعادة التأمين التعاوني (ش.م.س)

PROPOSAL FORM
MEDICAL MALPRACTICE INSURANCE
REGISTERED / LICENSED MEDICAL PRACTITIONERS
(CLAIMS MADE BASIS)

1. a. Proposer's Full Name and Postal Address ……………………………………………………………………………………
   ……………………………………………………………………………………
   b. Identity or C. R. Number……………………………………………………………………………………
   c. Telephone Number …………………… Telex ……………… Fax ……………………………………………

2. Location of Practice ……………………………………………………………………………

3. Please indicate the Limits of Indemnity required for :
   (i) Malpractice a. In respect of any one claim SR ……………………
   b. The aggregate amount during any one policy year SR……………………
   (ii) Public Liability a. In respect of any one claim SR ……………………
   b. The aggregate amount during any one policy year SR……………………

   NBI : ***3 (ii) above covering general Public Liability is optional on payment of additional contribution.***

4. a. At what Medical School(s) did you qualify ? ……………………………………………………………
   b. In what year(s) ? ……………………………………………………………
   c. With what degree(s) ? ……………………………………………………………

5. What branch(es) of the medical profession are you qualified and licensed to practice ? e.g. General Practice, Dentistry, Anesthesiology, Surgery, Nursing, Lab Technician etc.
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………
   ……………………………………………………………………………………………

6. Are you licensed in Saudi Arabia for the branch(es) of the medical profession you are practicing in Saudi Arabia?
   ……………………………………………………………………………………………..
   ……………………………………………………………………………………………..

7. a. Please name all partners and/or medically qualified employees. If none state none.
   ……………………………………….. ……………………………………………………
   ……………………………………….. ……………………………………………………
   b. Please state the number of employed (i)Technicians ………………… (ii) Nurses ………………
   (iii) Others (please specify) ……………………………

NB2 ***The answers to Question 7 are for office use only as the Policy will indemnify the Proposer only. If it is your intention to cover the individual liability of any of the stated persons included in your answers you must advise and further forms will be provided for completion and quotation.***

[Riyadh - Fax(+966) 1 405 5588 email: riyadh@medgulf.com] [Jeddah - Fax(+966) 2 675 7598 email: jeddah@medgulf.com] [Khobar - Fax(+966) 3 714 7557 email: khobar@medgulf.com]

8. If you are not self employed please indicate whether you are an employee of a Government Agency or the private health care section. (Please give details.)

……………………………………………………………………………………………………..
……………………………………………………………………………………………………..

9. Please advise whether you have had medical professional liability insurance during the past 12 months.

If YES, please give the name of the Insurer. Yes ☐ No ☐

……………………………………………………………………………………………………

10. Has any Insurer ever cancelled, declined, refused to renew or only accepted on special terms your professional liability insurance ? If YES, please give the name of the Insurer. Yes ☐ No ☐

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……………………………………………………………………………………………………

11. Have you ever been convicted for an act committed in violation of any law or ordinance (other than traffic offences) or been the subject of disciplinary proceedings or reprimand by any administrative agency or professional association ? If YES, please give the name of the Insurer. Yes ☐ No ☐

……………………………………………………………………………………………………
……………………………………………………………………………………………………

12. a. Have any claims or suits for negligence, error or omission been made against you ?
Yes ☐ No ☐

b. Are you aware of any claims or suits for negligence, error or omission that may have been made against any of your partners, assistants, nurses or technicians ? Yes ☐ No ☐

c. Are you aware of any circumstances which may result in any such claim or suit being made ?

If your answer to any of the above is YES, please give full details. Yes ☐ No ☐

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DECLARATION

I / WE HEREBY DECLARE that, to the best of my/our knowledge and belief, the above statements and particulars are complete and true and that I/We have not mis-stated or suppressed any material facts. (A material fact is one which is likely to influence acceptance or assessment of this proposal. If in any doubt whether facts are material, they should be disclosed). Submitting this form does not bind the Proposer to complete the insurance, nor to accept, but it is agreed that this form shall be the basis of the contract should a policy be issued.

Signature of Proposer : …………………………………….. Date : ………………………………

Cover will be on a Claims Made Basis. This means that the policy will only respond to Claims both made against you and notified to during the period of insurance.

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