

## PROPOSAL FORM (CLINICS)

- 1 Name and Principal address of the establishment(s) to be insured:
  
- 2 If other locations are to be covered by the proposed insurance, please list them hereunder together with the details of the use to which they are put.
  
- 3 Establishment(s) is (are) owned by:
  
- 4 How long had the establishment(s) been operated by the present owners?  
If changed, when?
  
- 5 Is (are) the establishment(s) licensed to operate at the addresses declared under 1 and 2 above?  
  
**YES**                       **NO**
  
- 6 State the number of employees in each of the following classifications:  
(Please state details regarding other departments and qualifications on a separate sheet)

Specialty	Number of Physicians	Qualification	Graduate from, when, experience
Anesthesiology			
Cardiology			
Dentist/ Orthodontist			
Dermatology			
ENT			
General Practitioner			
Gynecology			
Internal Medicine			
Neonatology			
Neurology			
Nuclear Medicine			
Obstetrics			
Ophthalmology			
Orthopedics			
Pediatrics			
Psychiatry			
Radiology			
Radiotherapy			
Transfusion medicine			
Traumatology			



Urology			
General Surgery			
Cardiac Surgery			
Dental Surgery			
Neurosurgery			
Pediatric Surgery			
Plastic Surgery			
Thoracic Surgery			
Vascular Surgery			
Others			

7 State the number, qualification and further education of the nursing staff:

8 Does the establishment employ?

- |                           |     |                          |    |                          |
|---------------------------|-----|--------------------------|----|--------------------------|
| a) Students               | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| b) Trainees               | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| c) X-ray technician       | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| d) Laboratory technicians | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| e) Other medical staff    | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

Please give details of the number and qualification

9 Does the establishment have?

- |  |     |                          |    |                          |
|--|-----|--------------------------|----|--------------------------|
| 24 h-readinesses with physician and nursing service? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 24 h-readinesses with specialty service?             | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

State the personnel availability at weekend and night:

10 State the number of beds available:

11 Medical-technical equipment:

- |                                |         |                          |    |                          |
|--------------------------------|---------|--------------------------|----|--------------------------|
| a) X-ray                       | YES     | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|                                | Number: | _____                    |    |                          |
| b) CT                          | YES     | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|                                | Number: | _____                    |    |                          |
| c) MRI                         | YES     | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|                                | Number: | _____                    |    |                          |
| d) Radiotherapy                | YES     | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|                                | Number: | _____                    |    |                          |
| e) Cardiac Catheterization lab | YES     | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|                                | Number: | _____                    |    |                          |
| f) Others                      | YES     | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|                                | Number: | _____                    |    |                          |



12 Other equipment:

- |                         |     |                          |    |                          |
|-------------------------|-----|--------------------------|----|--------------------------|
| a) Pharmacy             | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| b) Blood Bank           | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| c) Sperm Bank           | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| d) Nursing school       | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| e) Medical research lab | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

13 State the main surgical procedures, if any

14 State the standards existing in the establishment e.g. guidelines, nursing standards, hygiene and disinfection and the like:

15 Do you act with:

- |                        |     |                          |    |                          |
|------------------------|-----|--------------------------|----|--------------------------|
| a) Incident reporting? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| b) Peer reviews?       | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| c) Other Methods?      | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

16 Are you currently insured for Medical Malpractice, if yes please provide name of insurers.

17 What are the present policy limits.

18 What is the expiry date of the present policy?

19 Has any application for this type of insurance cover ever been ?

- |                            |     |                          |    |                          |
|----------------------------|-----|--------------------------|----|--------------------------|
| a) Declined?               | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| b) Cancelled?              | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| c) Required special terms? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

If the answer to any of the above is YES please give details

20 Limit of Indemnity required:

21 List any claim made against the establishment or its staff during the last 10 years.

Date of accident	Date of claim	Amount Claimed	Amount paid	Amount Outstanding	Details including the nature of the allegations and details of the claimant and relevant insurer

12 Have all the above been notified to and accepted by your previous insurer?

YES  NO

If NO, please give the details.

### Declaration

I/We declare that the statements and particulars in this proposal are true and that I/We have not mis-stated or suppressed any material facts. I/We agree that this proposal, together with any other information supplied by me/us shall form the basis of any contract of Insurance effected thereon. I/We undertake to inform Insurers of any material alteration to these facts whether occurring before or after completion of the Contract of Insurance. Signing this proposal form does not bind the Propose rot the Insurer to complete this insurance.

Authorised Signature of Applicant(s)

Date:

\_\_\_\_\_  
Name of Signatory

\_\_\_\_\_  
Position in the organization

\_\_\_\_\_  
Company Stamp

Forward to fax 04 2280601 or e-mail to [ajay@ngiuae.com](mailto:ajay@ngiuae.com)