

Professional Indemnity Insurance For Medical Practitioners Proposal Form

Special Scheme Arranged By Medical Risks & Claims Management Services (MRCM) for Medical Practitioners

SCHEDULE 9 OF THE FINANCIAL SERVICES ACT 2013 (FSA)

Pursuant to Paragraph 4 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for purposes related 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.

IMPORTANT NOTICE

Your attention is drawn to the sixty (60) days premium warranty attached to the Policy. By this warranty, the Insurance Policy is automatically cancelled unless the full premium is paid to the insurer within sixty (60) days from the commencement date of cover. Please note that if this insurance is transacted through your Insurance Broker, the Broker is acting on your behalf for the purpose of formation of this contract of insurance. It is important that you make full payment of the premium warranty so as to enable your Broker to remit the premiums early to your Insurer. You are advised to request your Broker to furnish you with the Broker's and Insurer's receipt on the premium that you paid.

Important Notice:

All premium and fees shown in this document may be subject to tax or other government levies.

Application Form for Medical Practitioners

Full Name : _____

NRIC No : _____

Primarily (Government) 1 Name and Address of Clinic : _____
 _____ Postcode : _____

Secondary (Private) 2 Name and Address of Clinic : _____
 _____ Postcode : _____

Period of Insurance : _____ to _____ E Mail Address : _____

Handphone No. : _____ Fax No. : _____

- 1 Please state the commencement of your first practising year _____
- 2 Please state the details of your first Professional Indemnity Insurance or Membership of a Defence Union/Protection Society :
 - a. Year of first insurance/membership D D M M Y Y Y Y
 - b. Name of first Insurance Company/Defence Union/Protection Society : _____

	YES	NO
3 Are you currently insured against your professional negligence ? If yes, please enclose a copy of your previous policy.	<input type="checkbox"/>	<input type="checkbox"/>
4 * Have you been subject to a reprimand ?	<input type="checkbox"/>	<input type="checkbox"/>
5 * Have any claims been made against you or negligence alleged against you to date?	<input type="checkbox"/>	<input type="checkbox"/>
6 * Are you aware of any circumstance which may result in a claim being made against you ?	<input type="checkbox"/>	<input type="checkbox"/>

* If any of the answer to Question No. 4,5 & 6 is YES, please provide details in a separate sheet.

Please attach a copy of the following documents with this application :

- a) Permanent Registration Certificate
- b) Annual Practicing Certificate

IMPORTANT NOTE
 Please note that the above premiums are in respect of new/renewal policies which have been claims free for the past three (3) years, otherwise the company reserves the right to revise the above premiums and terms accordingly.

Require for further details. Please do not hesitate to call the following personnel who would be glad to assist you :

Name	Contact No.	Email
i Dr. Ponnusamy	012 311 3934	dmuthaya5@gmail.com
ii Angie Ng	012 212 2013	angie.ng@zurich.com.my

Government Doctors		Exclude Tax (where applicable) & RM10 stamp duty	
	Limit of Liability (RM)	Premium* (RM)	Tick ✓
1. Government Doctors cover for Legal Advice & Representation in professional bodies	500,000	500	<input type="checkbox"/>
2. Government Doctors providing Locum Services			
a) In General Practices (GP Clinics)			
i) Core Services	1,000,000	700	<input type="checkbox"/>
ii) Core Services and Procedures	1,000,000	900	<input type="checkbox"/>
b) Private Hospital			
i) Outpatient Service	1,000,000	900	<input type="checkbox"/>
ii) ED (Emergency Department)	1,000,000	1,200	<input type="checkbox"/>
Private Medical Practitioners			
1 Core Services	1,000,000 1,000,000	950 1,300 with locum extension	<input type="checkbox"/> <input type="checkbox"/>
2 Core with procedures	2,000,000 2,000,000	1,250 1,700 with locum extension	<input type="checkbox"/> <input type="checkbox"/>
3 Asthetic/Complimentary/Alternative Practice (to enclose accreditation by MOH (Ministry of Health))	2,000,000 2,000,000	1,700 2,150 with locum extension	<input type="checkbox"/> <input type="checkbox"/>
4 Low Risk Specialise			
a) Occupational Health Physicians/Family Physicians	} 1,000,000	1,700	<input type="checkbox"/>
b) General Physicians			
c) Dermatology - Non-cosmetic			
d) Paediatrics - Non Neonatal (first 30 days of life)			
e) Pathology			
f) Psychiatry			
g) Endocrinology			
h) Rehab, medicine			
i) infections Diseases			
j) Geriatrics			
k) Radiology (Non Interventional)	2,000,000	2,950 with locum extension	<input type="checkbox"/>
5 Office Gynaecology (To provide list of services rendered)	1,000,000 2,000,000	7,500 10,000	<input type="checkbox"/> <input type="checkbox"/>

* The Premium is subject to Tax (where applicable) and RM10 Stamp Duty.

Total Premium _____

Tax (where applicable) _____

Stamp Duty RM10

Total Payable Amount _____

PAYMENT OPTIONS

a. Enclosed is a cheque no : _____ dated _____ for the amount of RM _____ payable to Zurich General Insurance Malaysia Berhad.

b. Please charge the total amount of RM _____ to my credit card.

MASTER VISA Card No. : _____

Name on Card : _____ Issuing Bank: _____

Expiry Date Cardholder's Signature _____

c. Online transfer to Zurich General Insurance Malaysia Berhad.
RHB Bank Berhad A/C No: 21406200052703 (enclose proof of payment)

DECLARATION AND SIGNATURE

I/We understand that it is my/our duty to take reasonable care not to make a misrepresentation in answering the question in this Proposal Form and I/we hereby declare that I/we have fully and accurately answered the questions above.

I/We hereby give my/our unconditional and unequivocal consent to you and all your related companies to process my/our personal data revealed hereto. You are at liberty to process the data and share the information revealed thereto with any of your service providers and your other related companies provided that the revelation of my/our personal data strictly for the purposes in related companies provided that the revelation of my/our personal data strictly for the purposes in relation to the insurance which I/we have applied hereto. The consent given hereto is in line with the requirement set forth in the Personal Data Protection Act 2010.

For details of our privacy notice, please visit www.zurich.com.my

Date :

Signature of Applicant: _____

VERIFICATION OF APPLICANT'S IDENTIFICATION

To be completed by Insurance Agents, Insurance Brokers or Staff of Insurance Companies

**ANTI-MONEY LAUNDERING, ANTI-TERRORISM FINANCING AND PROCEEDS OF UNLAWFUL ACTIVITIES ACT 2001
(AMLATFPUAA2001)
(VERIFICATION OF IDENTIFICATION OF PROPOSER)**

In compliance with Section 16(3) of the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001 (AMLATFPUAA 2001), I hereby certify that the Applicant's original NRIC No/Business Registration Certificate was verified and authenticated by me at the point of sales.

Third Party Verification

Signature of Insurance Agents, Insurance Brokers
or Staff of Insurance Companies

Name: _____

NRIC No.: _____

Date: _____

Note: A copy of the Applicant NRIC/Business Registration Certificate for Individual Insurance Policy must be submitted together with this proposal if the Premium exceeds RM50,000.