MPI GENERALI

MPI Generali Insurans Berhad (14730-X)

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MPI Generali Insurans Berhad is licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia.
MPI Generali Insurans Berhad dilesenkan di bawah Akta Perkhidmatan Kewangan 2013 dan dikawal selia oleh Bank Negara Malaysia.

MEDICAL MALPRACTICE INSURANCE PROPOSAL FORM FOR MEDICAL ESTABLISHMENTS (Hospitals, Clinics, Nursing Homes etc)

Pursuant to Paragraph 4(1) of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance for a purpose related to your trade, business or profession, you have a duty to disclose any matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it 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.

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*:**

- **Please answer ALL questions fully. If there is insufficient space, please provide details on your letterhead.**
- **Where provided, tick (√) appropriate box to indicate answer.**

1. (i) Full name of the Establishment:

(ii) How long has the Establishment been trading under the above name?

_____ months / years

2. Have you over engaged in similar activity under a different name? Yes No

If "YES" please see Question 4 below and provide full details in the same numerical order on a separate sheet

3. (i) Trading address

Street	
Town	
County/state	
Postal code	Country
Telephone Number	
Facsimile Number	

(ii) Registered Office (if different from above)

Street	
Town	
County/state	
Postal code	Country
Telephone Number	
Facsimile Number	

NB: If cover is required for additional locations or establishments, a separate proposal form for each must be completed. Please list on a separate sheet all locations or establishments for which cover is required.

4. GST Declaration (**Mandatory**)

Are you a GST Registrant? ☐ YES ☐ NO

If YES, please provide the following:

GST Registration No.:	_____
GST Registration Date:	_____
GST Registration Termination Date:	_____ *(if applicable)*
This insurance is purchase for :	☐ Personal Use ☐ Business Use

5. (i) The parent company or owner(s) is/are

(ii) What percentage(s) of shares in their ownership is/are held by:-

USA interest?_____%, Canadian interest? _____%

(iii) Who is the ultimate Owner or Holding Company

(iv) What percentage(s) of shares in their ownership is/are held by:

USA interest?_____%, Canadian interest? _____%

(v) Length of current operation by present Parent/Owner: _____months/years

(vi) What percentage of funds are generated from:

Government/Public? _____

Private funding? _____

Charitable donations? _____

(vii) What is/are the approximate percentages of patients from:

Government/Public? _____

Private funding? _____

Charitable donations? _____

(viii) What, if any, substantial charges in your activities or major new developments are likely to occur within the next 12 months? Please give full details

(ix) Are you licensed and registered in accordance with the applicable regulatory body or law to practice those procedures at the address specified in Question 3 for which indemnification is required? Yes No

If 'No' please give full details

(a) Are you a member of any Association or Professional Body, or registered with any self-regulating Organization? Yes No

If 'Yes' please state details

(b) Has membership of or registration with such ever been suspended, withdrawn, amended, declined or had conditions attached? Yes No

If 'Yes' please state full details:

(x) Please state your total Gross Fee Income/Turnover/Gross Receipts

(a) For the pass Financial Year _____

(b) Estimate for the current Financial Year _____

(c) Please state the period and commencement date of your Financial Year _____

6. Does the establishment have?

(i) An I.C.U/ I.T.U? Yes No

If 'Yes' Please state the number of beds _____

Average daily occupancy _____

(Note that above beds must be included in total shown in Question 6 below)

(ii) C.A.T/M.R.I. Scanners or similar? Yes No

If 'Yes' please provide details of any maintenance agreement

(iii) Medical teaching facilities? Yes No

(iv) Nursing teaching facilities? Yes No

(v) Pathology Laboratories? Yes No

(vi) Any ambulances owned/operated by the Establishment? Yes No

If "Yes", Please state the number: _____

7. (i) Please state the total number of beds and average daily occupancy:

	Number	A.D.O (%)
Beds		
Bassinets/Cribs/Cots		

(ii) Please state the total number of admitted in-patients

Last year: _____

Please state what, if any, percentage of your patients came from USA or Canada: _____ %

Please state what, if any, percentage of your clients who may be resident of the proposer's location but come from USA or Canada: _____ %

(iii) Please identify the approximate percentage of procedures performed on ADMITTED in-patients within the following categories:

Categories:	**Percentage:**
Accident & Emergency * *(Addendum 4)*	
Assisted Conception * *(Addendum 1)*	
Clinical Trials * (*Addendum 2)*	
Communicable Diseases	
Drug/Alcohol Dependency	
Dental	
Elective cosmetic	
Elective T.O.P	
Gender Reassignment	
Geriatric	
Maternity/Obstetric * *(Addenda 3 & 4)*	
Organ Transplant	
Pediatric	
Psychiatric	
Tropical disease	
Other Minor Surgery	
Intermediate Surgery	
Major Surgery	
Keyhole Surgery	
Total	**100%**

Where indicated with an * please complete section of the Addenda as indicated

(iv) Please state the number of Operating Theatres: _____

8. Please give details of any procedure(s) performed at any Out Patient Clinic(s) which is/are NOT included in the above information or set out in separate proposal form. Please specify the approximate number of patients treated and percentage of Gross Fee Income/Turnover/Gross Receipts derived during the past Financial Year.

Categories	**Patients Per Annual**	**% Gross Fee Income / Turnover Gross Receipts**
Antenatal Clinic		
Assisted Conception		
Dental		
Elective cosmetic		
Elective T.O.P		
HIV/HEP (inc. Counseling)		
Laser Eye Surgery		
Nutrition/Diet/Swimming		
S.T.D		
Sports Injury		
Well man		
Well woman		
Other Medical (*)		
Total Out-Patients		

(*) Please give details

9. Please NOTE that this policy is designed to cover claims made against your Establishment. If cover is also required for claims made against registered medical practitioners for work performed at your Establishment, please supply a list of all doctors for whom coverage is required stating the name, D.O.B qualifications and practice of each doctor. In addition to this, please confirm whether or not the doctors are employed by your Establishment or self-employed.

Please state the total number of persons involved in the following capacities

Categories:	**Employed by establishment**	**Not employed by establishment but self-employed**
Non procedural Physical:		
Psychiatrics		
Others		
Surgeons:		
Cosmetic		
Orthopedic		
Others		
Anesthetics		
Obstetrician / Gynecologist		
Gynecologist		
Lab/path technicians		
Dentist		

Midwives		
Nurse anesthesia		
Nurse – Day		
Nurse – Night		
Pharmacist		
Paramedics		
Residential Medical Officers		
Complementary Professional		
Supplementary Professional e.g.		
Radiographers, Theaters Technicians		
Auxiliaries – Day		
Auxiliaries – Night		
Directors/Partners/Principals		
Clerk/Administration		

Other (please specify)

10. Do you ensure and record that at all time all Registered Medical and Dental Practitioners are members of a Medical Dental Defence Organization, recognised by your National Medical/Dental Association, or otherwise fully Insured for their own Malpractice?

Yes No

If the answer is 'No', please refer back to the NOTE in question 8

11. Are any counselling services made available to patients? Yes No

If 'Yes'

(i) Please indicate in which of the following categories

Assisted Conception	
Drug/Alcohol Dependency	
Elective Cosmetic	
Elective T.O.P	
Gender Reassignment	
HIV/HEP/STD	
Sterilisation	

Other (please specify)

(ii) Please indicate number of Counsellors: _____

(iii) Do all Counsellors hold appropriate qualifications? Yes No

If "Yes", please provide details

(iv) Please indicate whether the Counsellors are employed by the Establishment or self-employed

12. Does any principal or other person involved in the treatment and care of any patient suffer from any disability or other impediment which may affect the performance of his or her professional duties or place patients at risk? Yes No

If 'Yes', please give full details:

13. (i) Do you have a blood bank? Yes No

(ii) Please state average number of units of blood or blood products used by your Establishment in any one calendar month:
_____

(iii) Is 100% of the above bought or obtained from your National Blood Transfusion Service or National Red Cross?
Yes No

If 'No', please give full details:

(iv) Are all blood or blood products tested for transmittable diseases in accordance with the National Blood Transfusion Service, National Red Gross Society or an equivalent body prior to use? Yes No

If 'Yes' please give full details:

If 'No', please give full details:

Please provide full details of storage facilities and procedures.

14. Please provide full details of what records are kept, where and how they are stored and for how long they are retained

Please note that it is a requirement of this policy that all records are retained for a minimum period of 7 years and in the case of minors, 7 years from majority

15. (i) Does the Establishment comply with current fire precaution/prevention legislation? Yes No

If 'No', please give details:

(ii) Are staff instructed and kept regularly appraised in fire and emergency procedures? Yes No

(iii) Do the premises have an emergency electrical system? Yes No

16. (i) Throughout the establishment do you provide facilities for safe selection storage and disposal in accordance with guidelines/legislation of:

(a) Sharps? Yes No

(b) Dressing, clinical /surgical waste etc Yes No

(ii) Do you ensure that the following are safely disposed of in accordance with current guidelines/legislation of:

(a) All blood/ blood products Yes No

(b) All other waste Yes No

(iii) Do you provide facilities within the Establishment for the sterilisation of instruments? Yes No

If "No" please provide details of what arrangements are in place for this:

If "Yes" do you ensure that the effective cross-infection control methods are employed?

PREVIOUS INSURANCE HISTORY

17. (i) Who are the present Malpractice and/ or Public Liability Insurers of the Establishment?

(ii) Has prior coverage been on a Claims Made Basis? Yes No

(iii) If "Yes" what is the retroactive date?

(iv) What are the present policy limits of insurance?

(v) What is the excess/deductible?

(vi) What is the expiry date of the present policy?

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

(i)	Declined	Yes	No
(ii)	Cancelled	Yes	No
(iii)	Required special terms	Yes	No

If the answer to any of the above is "Yes", please give details

19. List all claims made against the Establishment during the last 10 years. If none, please state "None":

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature of the negligence and details of Claimant

List all circumstances/complaints during the last 10 years which may rise to a claim being made against the Establishment. If "none", please state "None"

Dates of Circumstances/Complaints	Details including nature of the Complaint and details of the Complainant

20. (i) Have all of the above in question 19 been notified to your previous Insurers? Yes No

Date _____

If "Yes", give the date of notification

(ii) Have all of the above been accepted by your previous Insurers? Yes No

21. Please indicate which limit(s) of indemnity you require quotations for

☐ 1 million ☐ 2 million ☐ 3 million ☐ 4 million ☐ 5 million

☐ Other (please specify)

ADDENDUM 1 – ASSISTED CONCEPTION

If an Assisted Conception unit is maintained, please give a full percentage breakdown of all procedures undertaken:

Categories	**Percentage (%)**
A.I.H	
A.I.D	
I.V.F/E.T/P.R.O.S.T	
Frozen Embryo Replacement	
G.I.F.T	
Others (Please specify and indicate percentage)	

Are counseling services made available to patients? Yes No

Is all donor semen screened cryopreserved and quarantined in line with current recommendations? Yes No

ADDENDUM 2 – CLINICAL TRIALS

1. Please state for whom Clinical Research Projects are undertaken e.g. Pharmaceutical and other Manufactures, Charities, Research Foundations.

2. Do you receive a full indemnity form your Principals? Yes No

3. Do all volunteers sign an informed Consent Form? Yes No

4. If Double Blind studies are undertaken are volunteers made fully aware of this? Yes No

5. Do any trials involve any female volunteers of child – bearing age? Yes No

   If "Yes" please provide full details

6. Please list all members of all Ethics Committees authorising these trials

7. Please state the number of trials during the last 12 months detailing the number of volunteers in each trial

8. Please state the anticipated number of trials with which you will be involved during the next 12 months detailing the number of volunteers in each trial

9. Do you conduct any formal research, testing or experimental activities in the following categories? Yes No

Transplant	Human Embryo Research
Surgery	Artificial Organ
Obstetrics	Genetic Engineering

   If "Yes", please attach full details

10. Please provide a copy of your Volunteer Informed Consent Form and any indemnity referred to in question 2 above.

ADDENDUM 3 – MATERIAL/ OBSTETRICS

1. Please state the number of Deliveries per annum including:

Multiple Births	
Healthy Neotates	
Stillborn Infants	
Infants delivered at less than 32 weeks	
Infants delivered at less than 1501 grammes	
Infants with an Apgar rate of less than 6 at five minutes	
Number of infants admitted to the NICU/SCBU	
(i) From your own Obstetrical Department	
(ii) Transferred from entities outside the control of the Proposer	

2.	Is an Obstetrician available "in-house" 24 hours per day?	Yes	No
3.	Is a second Obstetrician on call 24 hours per day who is able to attend within 30 minutes	Yes	No
4.	Is a Pediatrician available in-house 24 hours per day?	Yes	No
5.	Is an Anesthetist available solely to the obstetrical department 24 hours a day?	Yes	No
6.	Is a second Anesthetist on call 24 hours per day who is able to attend within 30 minutes?	Yes	No
7.	Can emergency Caesarean sectors be performed within 30 minutes 24 hours per day	Yes	No
8.	Can Midwives attend births without an attending doctor?	Yes	No
9.	Can outside Doctors attend their own patients?	Yes	No

10. Please give brief details of the Proposer's policy in respect of mother and fetal monitoring

11.	Do you offer counseling service for parent following miscarriage, potential death or the birth of handicapped children?	Yes	No

ADDENDUM 4 – EMERGENCY CARE

1. Please indicate which of the following best describes the extent of emergency care provided by the Establishment

(i) Comprehensive emergency care is available 24 hours a day and includes anesthetic, medical and surgical services by resident medical staff, with other specialty consultation available within approximately 30 minutes

(ii) A Doctor is always presents in the emergency care area with specialty consultation available within approximately 30 minutes.

(iii) Emergency care is provided within approximately 30 minutes through a medical staff call roster

If "None" the above, please provide full details:

ADDENDUM 5 – INFECTION MANAGEMENT

1. What is your rate of nosocomial infections seen in your hospitals?

2. What areas do you see higher rates of nosocomical infections (OT, ICU, etc.)?

3. Are you using disposable drapes and gowns that provide impermeability or minimal strikethrough for body fluids?

   Yes No

4. Are your hand hygiene and infection prevention practices of your employees in the Operating Theatre and hospital in accordance with CDC guidelines? Yes No

5. Are your sterilization assurance and monitoring practices in accordance with CDC guidelines? Yes No

6. Do you use biological or chemical indicators to track sterilization assurance.

7. Do you use steam or EO gas for sterilization?

8. Is your focus on infection control or infection prevention? If infection prevention, how have you improved your practices and guidelines to decrease rate of nosocomial infections experienced by patients in your hospital.

9. Do your neighborhood clinics adhere to the same CDC guidelines as your hospitals?

10. What are your washing procedures for medical instruments and devices, particularly endoscopes and instruments that have small diameter tubes and narrow canulas?

11. Details on the Proposer's procedures to assure that single use disposable items are not re-used.

12. Details on the Proposer's infection management procedures to prevent Prion Contamination or transmission. In particular, are ALL reusable surgical equipment sterilized meeting the WHO Infection Control Guidelines for Transmissible Spongiform Encephalopathies and/or the Robert Koch Institute's minimum standards? Yes No

13. Full details on the Proposer's SARS infection management procedures. (Please attach)

Declaration

I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatever has been withheld which might increase the risk of the Insurers or influence the acceptance of this Proposal and should the above particulars alter in any way, I/We will advise the insurers as soon as practicable. I/We understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Insurers refusing to provide indemnity or voiding the policy in every respect. I/We hereby agree and accept that this Declaration shall be the basis of the contract be seen me/us and Insurers upon acceptance by me/us and of the Quotation afforded by the Insurers.

FOR AND ON BEHALF OF

(insert Company stamp)

NAME OF ESTABLISHMENT

SIGNATURE	DATED
NAME OF PROPOSER	POSITION

TO BE COMPLETED BY INSURANCE BROKERS, AGENTS OR STAFF OF MPI GENERALI INSURANS BERHAD

In Compliance with Section 16(2) of the Anti-Money Laundering Act 2001

I hereby certify that the Proposer's original NRIC/Business Registration Certificate was verified and authenticated by me at the point of sale.

Signature:

Name:

NRIC:

Date:

GOODS AND SERVICES TAX CLAUSE

The Insured and/or Insured Person agrees to pay and to hold harmless the Insurer / MPI GENERALI INSURANS BERHAD for any taxes or other government charges (however denominated) imposed by the government with respect to the execution or delivery of this Policy and/or Agreement.

PERSONAL DATA PROTECTION ACT 2010

MPI Generali Insurans Berhad is committed and have put in place a Privacy Policy to safeguard the security and confidentiality of your personal information with us. In using our services and website, you acknowledge and agree to be bound by the terms of our Privacy Policy which is available at www.mpigenerali.com