



Professional Indemnity Proposal Form

Part 1 - General Information

1. NAME OF INSURED

1.1 Title of Insured / Practice _____

1.2 P. O. Box _____ Code: _____ Town: _____

1.3 Telephone Number _____

1.4 Fax Number _____

1.5 E-Mail Address _____

1.6 VAT Registration Number _____

1.7 Present Legal Constitution (Mark relevant box below)

Sole Practitioner Partnership Incorporated Company Limited Company Close Corporation

2. ADDRESSES OF PRACTICE

	Address	Partner/Principal in Charge
2.1 Principal Office		
2.2 Subsidiary Office		

1. This proposal form has been compiled in such a manner as to provide Insurers with as much detail as possible with regard to evaluation of the Insurance requirements. Completion of this form does not bind the Proposer or Insurers to complete the insurance transaction.
2. To assist Insurers in accurately assessing liability for rating purposes, Proposers are requested to answer all the questions with either : Relevant details, “Yes”, “No” or “Nil” answers.
Where Yes / No answers are required please mark the appropriate box with an “X”.
3. Please answer **ALL** questions fully, replies such as “*see your records*”, or “*as previously advised*” are not acceptable.

If the space provided is insufficient, a separate sheet should be attached.

3. DATE OF COMMENCEMENT OF PRACTICE

3.1 As currently constituted _____

3.2 As initially established _____

4. DISCIPLINE(S) IN WHICH ENGAGED

5. NAMES AND QUALIFICATIONS OF PRINCIPALS

- i) In the case of Partnerships - Partners
- ii) In the case of Incorporated Companies - Directors
- iii) In the case of Limited Companies - Professionally qualified Directors and Employees
- iv) In the case of Close Corporations - Members

Name	Qualifications	Date Qualified	How long Principal in this Practice

6. Have any claims ever been made against the proposed Insured / Partners / Directors / Members or Employees for the type of cover for which you are now applying ?

YES NO

If YES; please give details.

7. Are any of the Proposed Insured / Partners / Directors / Members or Employees, AFTER ENQUIRY, aware of any circumstances which would be covered under a policy of this type that may result in any claims or a possible claim being made against them ?

YES NO

If YES; please give full details (attach page to the back if necessary).

8. Are you at present or have you in the past been Insured ?

YES NO

If YES; please state :

a) Name of Insurers _____

b) Indemnity Limit _____

Excess of Kshs. _____, each and every claim.

c) Date of Expiry of coverage _____

d) Whether Policy includes "Run-Off" Cover _____

and if so, for what period _____

9. Is Indemnity to apply to any Principal who has left / retired / died ?

YES NO

If *YES*; please state :

Name	Qualifications	Date Qualified	How long Principal in this Practice

10. For the type of Insurance now being proposed, has any Insurer ever :

a) Declined Proposal or renewal for this Practice or any Partner / Principal ?

YES NO

b) Required an increased premium or imposed special terms ?

YES NO

c) Cancelled an Insurance ?

YES NO

If any answer is *YES*; please give full details.

11. Do you require cover in respect of liability incurred but not discovered prior to the effecting of this insurance at a single premium to be negotiated ?

YES NO

DECLARATION

I/We hereby declare that the above statements and particulars contained in Parts 1 & 2 of this Proposal are true and complete, that at the present time, other than as stated, I/We have no reason to anticipate any claim under the insurance now being requested. I/We agree that this Proposal and declaration shall be the basis of the contract between me/us and the Insurers.

DATE : _____

SIGNATURE OF PROPOSER

NB :

IF THIS PROPOSAL IS BEING COMPLETED FOR THE RENEWAL OF AN EXISTING HERITAGE A.I.I. POLICY, PLEASE REMEMBER COVER LAPSES AUTOMATICALLY AT MIDNIGHT ON THE LAST DAY OF YOUR EXPIRING POLICY, UNLESS A WRITTEN EXTENSION NOT LONGER THAN 10 DAYS IS REQUESTED AND HAS BEEN GRANTED FROM INSURERS, OR RENEWAL TERMS HAVE BEEN ACCEPTED.