

Professional Indemnity Proposal Form For MEDICAL MALPRACTICE LIABILITY/ PRACTITIONERS

Part 2 - Additional Information

1.1 At what Medical School did you obtain your Qualifications ?

1.2 In what year did you qualify ?

1.3 What degree did you obtain ?

2. State whether you practice as a :
(Answer for each speciality)

a) Physician	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
b) Pathologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
c) Oncologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
d) Cardiologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
e) Psychiatrist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
f) Radiologist or Roentgenologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
g) General Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
h) Plastic Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
i) Orthopaedic Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
j) Urologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
k) Abdominal Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
l) Thoracic Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
m) Neuro-Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

2. n) Cardio-Vascular Surgeon

YES

NO

o) Otorhinolaryngologist

YES

NO

p) Proctologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
q) Opthamologic Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
r) Opthamologic Physician (excluding surgery)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
s) Obstetrician & Gynaecologist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
t) Physician and non-specialist Surgeon	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
u) Other Practitioner (<i>Describe Fully</i>)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

3. a) Name of Partners
(For insurance purposes each Partner is required to complete a Proposal Form)

b) If you are the employee of a practice :

(i) What is its title ?

(ii) Name all other employees of the corporation.
(Each qualified employee is required to complete a proposal form but proposals are not required for Technicians and Nurses other than Nurse Anaesthetists - Please attach a sheet if required).

c) If you are not the employee of a practice, please :

- (i) Name all qualified Assistants (each must complete a proposal form).
- (ii) Names of Nurse Anaesthetists (with qualifications).
- (iii) Names of Nurse Anaesthetists (with qualifications).
- (iv) Names of Other Nurses (with qualifications).

6. Of what Professional Associations or Societies are you a member in good standing ?

7. Do you advertise your business or profession :

a) other than as permitted by your National or Local Professional Association or Society ?

YES NO

b) other than by an entry in the yellow pages giving only your address and telephone number ?

YES NO

If YES; please give details.

8. State approximate division of your work and indicate if you require coverage for the following :

	Work	Percentage of Total Work Performed			
a)	The prescription or fitting of Contact Lenses.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
b)	Hypnosis.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
c)	The treatment of mental illness, drug addiction or alcoholism.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
d) (i)	Diagnostic X-Ray procedures (other than plain X-Ray).	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
(ii)	Angiographic procedures and Cardiac Catheterisation.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
(iii)	Administration of spinal, caudal, epidural or general anaesthesia.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
e)	Plastic Surgery (<i>other than minor skin grafts</i>).	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
(i)	Traumatic.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
(ii)	Cosmetic.	%	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
g)	Major Surgery, which shall be defined as :				

(i)	Orthopaedic Surgery (<i>other than orthopaedic operations on the smaller joints</i>).	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(ii)	Neuro-Surgery.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(iii)	Amputation of Limbs.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(iv)	Plating, pinning open reduction of fractures.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(v)	Procedures involving entry surgically or otherwise into the spine, thorax or skull.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(vi)	Procedures involving entry surgically or otherwise in the abdomen (<i>other than procedures concerned with normal delivery which may include episiotomy and application of low forceps</i>).	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(vii)	Mastectomy.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(viii)	Resection of facial bones and tissues.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(ix)	Operations on the organs of the neck (<i>other than biopsy excision of lymph nodes</i>).	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
	Work					
		Percentage of Total Work Performed				
(x)	Reconstructive vascular surgery and thromboembolctomy of the larger arteries and veins.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xi)	Ophthalmic Surgery.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xii)	Mastoidectomy.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xiii)	Operations on the inner ear.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xiv)	Oesophagoscopy.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xv)	Exchange Transfusions.	%	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
h)	Intermediate Surgery which shall be defined as :					
(i)	Tonsillectomy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(ii)	Adenoidectomy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(iii)	Closed reduction of fractures.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(iv)	Surgical or injection treatment of varicose veins.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(v)	Orthopaedic operations on the smaller joints.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(vi)	Amputation of digits.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(vii)	Dilation and curettage.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

(viii)	Culdoscopy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(ix)	Cytoscopy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(x)	Gastroscopy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xi)	Sigmoidoscopy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xii)	Bronchoscopy.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xiii)	Biopsy excision of lymph nodes.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
(xiv)	Circumcision.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
i)	General Practice which in no circumstances includes any of the procedures in 9(h) above.		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
j)	Any other procedure (<i>please describe</i>).		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

N.B. Coverage is afforded only in respect of the procedures listed in 9 (h) above for which a specific premium has been paid and in addition for General Practice. If coverage is required for any other procedures, such procedures must be specifically declared.

9. Have you or any of your Partners, Assistants, Technicians or Nurses any physical, physiological, emotional, pathologic or psychiatric disability ?

YES NO

If YES; please give details.

10. Are you in the employ of any individual, firm or group (other than that referred to in above), hospital of any category) or health facility of any kind ?

YES NO

If YES; please give details.

11. Are you under contract to any individual, firm or group, hospital (of any category) or health facility of any kind ?

YES NO

If *YES*; please give details.

12. Are you engaged in any additional medical activities for which you receive payment ?

YES NO

If *YES*; please give details.

13. Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered ?

YES NO

If *YES*; please give details.

14. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offences ?

YES NO

If *YES*; please give details.

15. Have you ever been the subject of disciplinary proceedings or reprimand by an administrative body or a professional association ?

YES NO

If YES; please give details.

16. Please state amount of insurance required (Maximum Kshs.....) inclusive of costs and expenses.

Kshs. _____ any one patient.

17. FEE INCOME

(This question must be completed accurately as the figures are used for rating purposes)

a) Please give gross fees received during the past five years :

Year	Gross Fees	Year	Gross Fees
	Kshs.		Kshs.
	Kshs.		Kshs.
	Kshs.		

b) Please give the estimated fees for the coming 12 months. Kshs. _____