Tawuniya التعاونية

Medical Malpractice Insurance Proposal Form (Individuals)

Applicant's Details

Applicant's Name: _____ Nationality: _____ ID/Iqama No.: _____

Date of Birth: ____/____/____ E-mail: _____ Twitter: _____

Mobile: _____ Tel. (home): _____ Tel. (office): _____ Ext.: _____ Fax: _____

Address (Wasel):

Zone: _____ City: _____ District: _____ Street: _____

Building No.: _____ Unit No.: _____ Zip Code: _____ Additional No.: _____

Number of employees (full time): _____

Annual revenue. (in case of selection) Please provide us with a copy of the audited financial statements for the last financial year.

☐ Less or equal than SR 3 million ☐ More than SR 3 million up to SR 40 million

☐ More than SR 40 million up to SR 200 million ☐ More than SR 200 million

SCHS Registration No. _____ Expiry Date: _____

Please state which branch of Medical Profession you are qualified and licensed to practice in KSA:

Category (A)

☐ Nurse ☐ Lab/Path Tech ☐ Scanning Tech ☐ X-Ray Tech

☐ Paramedic ☐ Physiotherapist ☐ Pathologist ☐ Dietician

Category (B)

☐ Midwives ☐ Pediatrician (Non Surg) ☐ Nephrologists ☐ Ophtalmologist

☐ General Practitioner ☐ Psychiatrist ☐ Radiology ☐ Dentist

Category (C)

☐ Surgeon

Please indicate limit of indemnity required:

Limit of Indemnity	
☐ SR 100,000 Any One Claim (Any One Claim) and in the Annual Aggregate	☐ SR 300,000 Any One Claim and SR 500,000 in the Annual Aggregate
☐ SR 250,000 Any One Claim and in the Annual Aggregate	☐ SR 300,000 AOC and SR 1,000,000 in the Annual Aggregate
☐ SR 250,000 Any One Claim and SR 500,000 in the Annual Aggregate	☐ SR 500,000 Any One Claim and in the Annual Aggregate
☐ SR 250,000 AOC and SR 1,000,000 in the Annual Aggregate	☐ SR 500,000 AOC and SR 1,000,000 in the Annual Aggregate
☐ SR 300,000 AOC and SR 300,000 in the Annual Aggregate	☐ SR 1,000,000 Any One Claim and in the Annual Aggregate

Period of Insurance Required: ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years

From: _____ To: _____

Your Qualification: ☐ Graduation ☐ Post Graduation ☐ Super Speciality/Fellowship (Please specify): _____

Years of Experience in the area of specialization:

☐ 0 to 5 Years ☐ 6 to 10 Years ☐ 11 to 20 Years ☐ Above 20 Years

Employment Details: ☐ Gov't. Hospital ☐ Private Hospital ☐ Private Clinic ☐ Own Practice

Location of Practice: ☐ Riyadh ☐ Dammam/Al Khobar ☐ Jeddah ☐ Makkah ☐ Other (Please Specify): _____

8-2018.V1.PC-3

1. Please advise whether you have had medical medical malpractice insurance during the past 12 months. ☐ Yes ☐ No
   If YES, please give the name of the insurer, Policy No., Expiry date, etc.

2. Has any insurer ever cancelled, declined, refused to renew or accepted only on special terms your medical malpractice insurance?
   ☐ Yes ☐ No
   If YES, please give details:

3. Have you ever been convicted for an act commited in violation of any law or ordinance (other than traffic offenses) or been the subject of disciplinary proceedings or reprimand by any administrative agency of professional association? ☐ Yes ☐ No
   If YES, Please give details:

4. Have any claims or suit for negligence, error or omission been made against you? ☐ Yes ☐ No
   If YES, please give details:

5. Are you aware of any claims or suits for negligence, error, omission that may have been made against any of your partners, assistants, nurses or technicians employed by you? ☐ Yes ☐ No
   If YES, please give details:

6. Are you aware of any present circumstances which may result in any such claims or suit being made against you in future? ☐ Yes ☐ No
   If YES, please give details:

Credit Card Details

Card Type: ☐ VISA ☐ MasterCard ☐ American Express

Card No.:

Expiry Date: Month ☐☐ Year ☐☐

Note: Credit Card should be that of the applicant.

Declaration

- I hereby declare that to the best of my knowledge and belief, the above statements and particulars are complete and true and that I have not mis-stated or suppressed any material facts (a material fact is one which is likely to influence Tawuniya's acceptance or assessment of this proposal. If any doubt whether facts are material, they should be disclosed).
- I declare that i preview and agree on Medical Malpractice Insurance.

  Submitting this form does not bind the applicant to complete the Insurance, nor Tawuniya to accept, but it is agreed that this form shall be the basis of the contract should a policy be issued.

  I have authorized Tawuniya to charge me the amount of SR _____ as premium contribution on my Credit Card as per the details given above.

Applicant's Signature: _____ Date: _____

Important Note

THE COVER WILL BE ON A CLAIM MADE BASIS. THIS MEANS THAT THE POLICY WILL ONLY RESPOND TO CLAIMS (ARISING FROM EVENTS OCCURING AFTER THE COMMENCEMENT OF THIS POLICY) MADE AGAINST YOU AND NOTIFIED TO TAWUNIYA DURING THE PERIOD OF INSURANCE.

* The insurance products provided by Tawuniya Insurance Company are subject to Value Added Tax (VAT), except life insurance (Takaful). A 5% of the premiums and administrative fees are added to all policies issued starting from 1 January 2018.