

Medical Malpractice Insurance Proposal Form (Individuals)

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Applicant's Details

Applicant's Name: _____		Nationality: _____		ID/Iqama No.: _____	
Date of Birth: ____/____/____		E-mail: _____		Twitter: _____	
Mobile: _____	Tel. (home): _____	Tel. (office): _____	Ext.: _____	Fax: _____	
<input type="checkbox"/> Wasel	Zone: _____	City: _____	District: _____	Street: _____	
	Building No.: _____	Unit No.: _____	Zip Code: _____	Additional No.: _____	
<input type="checkbox"/> Postal Add.	City: _____	P.O. Box _____	Zip Code: _____		

SCHS Registration No. _____	Expiry Date: _____
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Please state which branch of Medical Profession you are qualified and licensed to practice in KSA:

Category (A)

- | | | | |
|------------------------------------|--|--|-------------------------------------|
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Lab/Path Tech | <input type="checkbox"/> Scanning Tech | <input type="checkbox"/> X-Ray Tech |
| <input type="checkbox"/> Paramedic | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Pathologist | <input type="checkbox"/> Dietician |

Category (B)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Midwives | <input type="checkbox"/> Pediatrician (Non Surg) | <input type="checkbox"/> Nephrologists | <input type="checkbox"/> Ophthalmologist |
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Radiology | <input type="checkbox"/> Dentist |

Category (C)

- Surgeon

Please indicate limit of indemnity required:

Limit of Indemnity	
<input type="checkbox"/> SR 100,000 Any One Claim (Any One Claim) and in the Annual Aggregate	<input type="checkbox"/> SR 300,000 Any One Claim and SR 500,000 in the Annual Aggregate
<input type="checkbox"/> SR 250,000 Any One Claim and in the Annual Aggregate	<input type="checkbox"/> SR 300,000 AOC and SR 1,000,000 in the Annual Aggregate
<input type="checkbox"/> SR 250,000 Any One Claim and SR 500,000 in the Annual Aggregate	<input type="checkbox"/> SR 500,000 Any One Claim and in the Annual Aggregate
<input type="checkbox"/> SR 250,000 AOC and SR 1,000,000 in the Annual Aggregate	<input type="checkbox"/> SR 500,000 AOC and SR 1,000,000 in the Annual Aggregate
<input type="checkbox"/> SR 300,000 AOC and SR 300,000 in the Annual Aggregate	<input type="checkbox"/> SR 1,000,000 Any One Claim and in the Annual Aggregate

Period of Insurance Required:	<input type="checkbox"/> 1 Year	<input type="checkbox"/> 2 Years	<input type="checkbox"/> 3 Years
	<input type="checkbox"/> 4 Years	<input type="checkbox"/> 5 Years	

Your Qualification:	From: _____	To: _____
	<input type="checkbox"/> Graduation	<input type="checkbox"/> Post Graduation
	<input type="checkbox"/> Super Speciality/Fellowship (Please specify): _____	

Years of Experience in the area of specialization:




- | | |
|---|---|
| <input type="checkbox"/> 0 to 5 Years | <input type="checkbox"/> 6 to 10 Years |
| <input type="checkbox"/> 11 to 20 Years | <input type="checkbox"/> Above 20 Years |

Employment Details:	<input type="checkbox"/> Gov't. Hospital	<input type="checkbox"/> Private Hospital
	<input type="checkbox"/> Private Clinic	<input type="checkbox"/> Own Practice

Location of Practice:	<input type="checkbox"/> Riyadh	<input type="checkbox"/> Dammam/Al Khobar	<input type="checkbox"/> Jeddah
	<input type="checkbox"/> Makkah	<input type="checkbox"/> Other (Please Specify): _____	

1. Please advise whether you have had 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 committed 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:   

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.