GA INSURANCE LIMITED
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Fax 2714542, Phone 2711633, <insurer@gakenya.com>

Professional Indemnity Proposal Form

Part 1 – General Information

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 the Insurers to complete the insurance transaction.
2.	To assist Insurers in accurately assessing liability for rating purposed, Proposers are requested to answer all the questions with either: Relevant details, "Yes" or "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.

1. NAME OF INSURED

1.1 Title of Insured/Practice _____

1.2 Telephone Number _____

1.3 Fax Number _____

1.4 E-Mail Address _____

1.5 VAT Registration Number _____

1.6 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		

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 Partnership – 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 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 _____

c) Date of Expiry of coverage _____ each and every claim

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 ?

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.

_____

_____

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 contract between me/us and the Insurers.

Date: _____ _____

SIGNATURE OF PROPOSER

NB: **Please proceed to complete Part 2 – Additional Information**

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 WRITTED EXTENSION NOT LONGER THAN 10 DAYS IS REQUESTED AND HAS BEEN GRANTED FROM INSURERS, OR RENEWAL TERMS HAVE BEEN ACCEPTED.

MEDICAL MALPRACTICE LIABILITY
HOSPITALS/CLINICS

Part 2 – Additional Information
STAFF COMPLEMENT

Please state the number of employees in each of the following classifications:

1.1 Medical Staff

Specialized in:

a) Surgeons _____

b) Doctors of Medicine _____

c) Radiologists _____

d) Radiographers _____

e) Laboratory Technicians _____

f) Pharmacists _____

1.2 Nursing Staff

Name of Director of Nursing	Qualifications	Year(s) Obtained

a) Number of Auxiliary Nurses _____

b) Number of Student Nurses _____

2.1 Please state your immediate past Financial Year End: _____

2.2 Please state:

	Immediate Past Financial Year End	Previous Financial Year End
a) Gross Revenue of the Hospital/Clinic	Kshs.	Kshs.
b) Gross Revenue relating to Rentals/Lease etc	Kshs.	Kshs.
c) Gross Revenue from Medical Procedures/ Pharmacies or any other Medical Treatment.	Kshs.	Kshs.
d) Gross Revenue from any other sources. (*Give brief details)*	Kshs.	Kshs.

4. QUOTATIONS REQUIRED

a)

Limit of Indemnity	
Kshs.	any one period of insurance inclusive of costs and expenses
Kshs.	any one period of insurance inclusive of costs and expenses
Kshs.	any one period of insurance inclusive of costs and expenses

b) DEDUCTIBLE (EXCESS)
(The amount carried by the Insured per claim)

Excess	
Kshs.	each and every claim.
Kshs.	each and every claim.
Kshs.	each and every claim.

4. 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:

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

5. Does the Insured wish to be indemnified for liabilities resulting from AIDS or any syndrome connected therewith. YES ☐ NO ☐

6. Is there any further information that should be made known to the company in order that they may form a proper estimate of the risk? YES ☐ NO ☐

(*Please attach any relevant publications or brochures)*