

# PROPOSAL FORM 2018

## PROFESSIONAL INDEMNITY INSURANCE

Endorsed by:



Insured by:

PACIFIC & ORIENT INSURANCE CO BHD



## IMPORTANT NOTICES

1. Pursuant to Paragraph 4 (1) of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance for a purpose related to your trade, business or profession, you have a duty to disclose any matter that you know to be relevant to Insurers' decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance.
2. The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us. You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in this Proposal Form is inaccurate or has changed.
3. This Proposal Form must be completed and signed by you. If the Form is completed by any other person, you must ensure that you are aware of all information stated herein.

## SECTION 1: PERSONAL DETAILS

Full Name			
NRIC No. / Passport		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		Telephone No.	
Email		Mobile No.	
MMC No.		MMA Member	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address			
Postal Code		City	
State		Country	
Primary Place of Practice		Secondary Place of Practice (if applicable)	

Please attach copies of your Annual Practicing Certificate and the Full Registration Certificate with this Proposal Form.

## SECTION 2: INSURANCE HISTORY

1. Do you currently have medical professional indemnity insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'YES', please provide further details:	
a. Name of Current Indemnity Provider / Insurer	
b. Expiry Date of Current Policy	
2. Have you ever had any medical professional indemnity insurance before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'YES', please provide further details:	
a. Name of Indemnity Provider / Insurer	
b. Period of Insurance	
3. Have you ever been refused medical professional indemnity before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'YES', please provide further details:	

### SECTION 3: CLAIMS HISTORY

1. Are you aware of any claim or threat against you now or have you ever been involved, directly or indirectly in a claim, or suit arising from your practice? ☐ Yes ☐ No
2. Are you aware of any circumstance or incident that may give rise to a claim against you in the future? ☐ Yes ☐ No
3. Have you ever been subjected to any disciplinary / coronial inquiry, investigation or complaint by a regulatory body or council (e.g. MMC)? ☐ Yes ☐ No

If you have answered "YES" to any of the above questions, it is important to complete following table and attach any relevant documents with regard to your claim, circumstance, inquiry or investigation. You may use Section 6 to provide more details if necessary.

No.	Date of Notification to Insurer (Writ / Letter of Demand / Circumstance)	Name of Claimant(s) / Potential Claimant(s) with Brief Details	Estimated / Actual Amount for Claim including Legal Costs	Settled (Yes / No)
1				
2				
3				

### SECTION 4: POLICY DETAILS

#### A. MEDICAL STATUS & REGISTERED SPECIALTY

#### B. SUBSCRIPTION LIMIT (PER ANNUM)

Please tick the appropriate box and provide your registered specialty (if any) and refer to Section 5 & Attachment 1

- ☐ General Medical Practitioner  
☐ General Medical Practitioner with Obstetrics  
☐ Low Risk   
☐ Medium Risk   
☐ High Risk   
☐ Additional Specialty

- ☐ RM 1,000,000  
☐ RM 1,500,000  
☐ RM 2,000,000  
☐ RM 3,000,000  
☐ RM 5,000,000  
☐ RM 10,000,000  
☐ Additional Limit Reinstatement

Insurance to Commence From

to

**\*\*Premium Payable:**  RM

Reminder: Please add 10% if you opt for Additional Limit Reinstatement.

**\*\*Pro-rated premium will be charged for periods less than 12 months and up to maximum 18 months.**

## SECTION 5: CATEGORIES OF SPECIALTIES

### GENERAL MEDICAL PRACTITIONERS WITH OBSTETRICS

- Care of Patient and Management of Pregnancy Beyond 24 Weeks Gestation excluding Deliveries

### SPECIALTY - LOW RISK

- |                                   |   |
|-----------------------------------|---|
| • Audiological Medicine           | • Oncology  |
| • Blood Transfusion               | • Ophthalmology with No Laser Refractive Surgery – Except Cataracts |
| • Clinical Cytogenetics           | • Paediatrics   |
| • Clinical Genetics               | • Palliative Medicine   |
| • Clinical Immunology and Allergy | • Pathology   |
| • Cosmetic and Aesthetic*         | • Pharmaceutical Physician  |
| • Dermatology                     | • Physiology  |
| • Endocrinology                   | • Public Health   |
| • General Medicine                | • Preventative Medicine   |
| • Genito-urinary Medicine         | • Psychiatry  |
| • Geriatric Medicine              | • Rehabilitation Medicine   |
| • Haematology                     | • Renal Medicine  |
| • Immunology                      | • Respiratory Medicine  |
| • Infectious Diseases             | • Rheumatology  |
| • Nephrology                      | • Sports Medicine   |
| • Nuclear Medicine                | • Thoracic Medicine   |
| • Occupational Health             |   |

- \* Non-invasive elective topical enhancement of patient's external appearance, including injections.

### SPECIALTY - MEDIUM RISK

- |   |   |
|---|---|
| Accident and Emergency                      | Neonatology                             |
| Anaesthetics                                | Neurology                               |
| Cardiology                                  | Ophthalmic Surgery                      |
| Cardiothoracic Surgery                      | Oral and Maxillo-Facial Surgery         |
| Colorectal Surgery                          | Otorhinolaryngology (Ear, Nose, Throat) |
| Cosmetic and Aesthetic                      | Paediatric Surgery                      |
| Endocrine Surgery                           | Radiology                               |
| Gastroenterology                            | Radiotherapy                            |
| General Surgery excluding Bariatric Surgery | Thoracic Surgery                        |
| Intensive Care                              | Urology                                 |
|   | Vascular Surgery                        |

### SPECIALTY - HIGH RISK

- |   |  |
|---|--|
| Bariatric Surgery   | Orthopaedic and Trauma Surgery   |
| Cosmetic and Aesthetic Surgery: <i>Elective Alteration of Patient's External Appearance</i>       | Plastic and Reconstructive Surgery   |
| Gynaecology   | Spinal Surgery: <i>Treatment and Management of Spinal Trauma, Degenerative Diseases / Conditions, Deformities, Infections and Tumours, including but not limited to, Stabilization with Instrumented Fusion for Degenerative and Neoplastic Conditions</i> |
| Neurosurgery  |  |
| Obstetrics and Gynaecology: Care of Patient and Management of Pregnancy Beyond 24 Weeks Gestation |  |

## SECTION 6: ADDITIONAL INFORMATION

## SECTION 7: SUBMISSION & METHODS OF PAYMENT

The completed Proposal Form can be submitted via Post / Fax / Email as shown below:

JARDINE LLOYD THOMPSON SDN BHD  
42-01, Level 42, Q Sentral,  
2A Jalan Stesen Sentral 2,  
50470 Kuala Lumpur

T : +60 3 2723 3388  
F : +60 3 2723 3399  
E : mpi@jltasia.com

### METHODS OF PAYMENT

1. By Cheque to JLT SDN BHD    Cheque No.

2. By Bank Transfer To

HSBC AMANAH MALAYSIA BERHAD

Account Name : Jardine Lloyd Thompson Sdn Bhd

Account No. : 001-503556-022

Please attach a copy of your Bank Transfer Slip for confirmation of payment.

3. By JomPay

Biller Code : 4143

Reference 1 : Your Full Name

Reference 2 : Your NRIC

Please attach a copy of the Transaction Slip for confirmation of payment.

Please note that cover is subject to the terms and conditions of the policy. The process for cover may take 3 - 10 business days.

## SECTION 8: DECLARATION

### A. AUTHORITY TO INSURERS AND OTHER PARTIES

Authorisation: I/We hereby authorise Insurers and/or Adjusters and/or Lawyers to disclose from time-to-time such information arising from any claim under the insurance cover for the sole purpose of the management of Scheme and its Risk Management objectives. These include negotiating, maintaining or renewing insurances, and handling insurance claims. At times, the provision of services of JLT as Brokers may necessitate the transfer of personal data and/or the disclosure of the same to companies within the JLT Group, Insurers, partners, agents, affiliates and professional advisers.

### B. PERSONAL DATA PROTECTION ACT 2010

Insurer is committed and has put in place a Privacy Policy to safeguard the security and confidentiality of your personal information with us. In using our services and website, you acknowledge and agree to be bound by the terms of our Privacy Policy.

### C. PERSONAL INFORMATION

During the normal course of business as described in a. above, we may use your or your employees' (collectively stated as "your") personal information for the following purposes: (a) to process your application; (b) to administer and process insurance policies, insurance claims and medical claims, security and underwriting checks; (c) to process payment instructions; (d) to verify your eligibility for insurance, financial or wealth management products and services; (e) to evaluate your financial needs; (f) to design and provide you with insurance, financial and related services and products; (g) to conduct identity and/or credit checks and/or debt collection; (h) to communicate with you; (i) to provide you with promotional materials relating to insurance or financial services or related wealth management products arranged by JLT, and those of other entities whose ultimate parent company is JLT Group Plc ("companies within the JLT Group") or partnering insurance companies or financial institutions; (j) to perform a policy review or needs analysis; (k) to conduct research and statistical analysis; (l) to comply with the laws of any applicable jurisdiction

or to meet disclosure requirements imposed by law or regulatory authorities; (m) to match any information/ data held which relates to you from time to time for any of the purposes listed herein; (n) to carry out other services in connection with the operation of JLT's business; and (o) for other purposes directly relating to any of the above. Under the Personal Data Protection Act 2010, you may have right of access to the information we hold about you, or to have inaccurate information corrected.

### D. DECLARATION

1. My medical license or my privileges at any hospital or institution have never been revoked, suspended, restricted, or placed on probation;
2. I have never been investigated by any licensing board, narcotics board, or other governmental or regulatory agency nor any fee or professional relations complaints have ever been filed against me with medical associations, hospitals or licensing authorities;
3. I have not been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses;
4. No allegation or claim has ever been made against me regarding sexual harassment, sexual intimacy, exploitation or sexual assault in the conduct of my practice or otherwise;
5. I have never intentionally altered or falsified patient records or knowingly made any change, correction, or addition without properly noting it as such;
6. I have never been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness;
7. With respect to my professional indemnity coverage, no insurance company or mutual has ever canceled, refused to renew or restricted my coverage.

☐ I am unable to make the above declaration for my professional history due to the reason(s) below:

I hereby declare and warrant that after enquiry, all the statements and particulars contained in this Form are true, and no information whatsoever has been withheld which might increase the risk of the Insurers or influence the acceptance of this proposal. Should the above particulars alter in any way, I will inform the Insurers as soon as it is practicable. I understand that failure to disclose any material fact which would be likely to influence the acceptance and assessment of the proposal may result in the Insurers refusing to provide indemnity or will invalidate the policy in every respect.

I agree and accept that this declaration shall be the basis of contract between myself and the Insurers upon the acceptance by me of the quotation afforded by the Insurers.

Date

Signature

Official Stamp

Name





MANAGED BY  
JARDINE LLOYD THOMPSON SDN BHD  
(016674-K)

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