



THE CIC INSURANCE GROUP LIMITED
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PROPOSAL FORM FOR MEDICAL MALPRACTICE INSURANCE FOR PHARMACISTS, RADIOLOGISTS, PHYSIOTHERAPISTS, CLINICAL OFFICERS AND QUALIFIED ASSISTANTS

- 1. Answer all questions fully, replies such as "see your records" or "previously advised" are not acceptable.
2. Signature of this proposal does not bind the proposer/insurer to complete the insurance contract.
3. In the case of a renewal, the proposal needs to be completed and returned prior to renewal to provide for continuation of cover.
4. This is a claims made policy i.e. the policy must be in force when a claim is first made.

1. Full Name of Proposer.
2. Physical Address of where you practice or where you are employed
Postal Address
Telephone Numbers: Work Home
3. At what institution did you graduate?
4. With what Degree and or certificate did you graduate? (Attach Copies)
5. Where have you practiced your profession since graduation?
In During the years
6. Do you belong to any Professional Association/Societies? YES/NO

7. Please list below, the disciplines in which you are practicing:-

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8. If you are not an Employee of a Practice and practice on your own:

Name all Qualified Assistants (each must complete a Proposal Form)

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9. Do you own(wholly or part), operate or administer any Hospital, Nursing Home or other Institution where medical services are rendered YES/NO

if yes please give details.

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10. Are you in the employ of, or under contract to any Individual Firm, Hospital or Health Facility of any kind? YES/NO

If yes please give details

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11. Are you engaged in any Professional Activities, other than full time occupation, either paid/unpaid?

YES/NO

If yes, please give details:

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12. Are you presently insured, or have you previously been insured against Medical Malpractices Risk?

YES/NO

If yes, please give details:

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13. Have any claims for malpractice been made against you? If so ,please give particulars:

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14. Are you aware of any circumstances that may result in a claim being made against you? if so, please give details:

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15. Has any application made by you been declined, had special terms imposed any policy cancelled? if so, please give details.

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16. Cover required: Limit of Indemnity KSH:

Premium Due KSH.....

Cover is based on the proposer being responsible for the first 10% of loss Minimum Ksh. 100,000

I/WE hereby declare that the statements and particulars in this Proposal are True and complete and that to the best of our knowledge I/WE have not misstated or suppressed any material facts. I/WE agree that this proposal together with any information supplied by me/us shall form basis of any Contract of Insurance affected between the Firm and the Insurers.

I/WE undertake to inform the Underwriters of any material alterations to these facts, occurring before the completion of the Contract of insurance, during the subsistence of such Contract.

This proposal form does not bind the proposer or underwriter to complete this insurance.

Dated this _____ day of _____ 20____

For and on behalf of _____
(Insert name of proposer)

Signature of partner or principal _____

Signed/Endorsed by Clinical Officers Council _____
(Signed over COC rubber stamp)

Name of person/officer on behalf of Clinical Officers
Council _____

Agent/Broker Name _____

We keep our word