दि ओरिएण्टल इंश्योरेंस कम्पनी लिमिटेड
The Oriental Insurance Company Limited

THE ORIENTAL INSURANCE COMPANY LTD.

(A Govt. of India Undertaking)

PROPOSAL FORM FOR MEDICAL ESTABLISHMENT

ERRORS & OMMISSIONS INSURANCE

This Proposal must be signed. All questions must be answered. The completion and signature of this proposal does not bind the proposer or insurer to complete a contract of insurance. If the space is insufficient to answer question, Please use additional sheets and attach it to this form. The company does not assume any liabilities until Proposal has been accepted and premium paid.

1) **Name of proposer**

   Address

2) **Year in which established :**
3) **Names & Address of owner/directors/partners**

4) **Have You complied with all statutory rules/ regulations, relating to your establishment.**
5) **Are the Doctors/Nurses/Technicians working for you**
   (a) **Duly licensed in accordance with the medical acts or any other prevalent laws.**
   (b) **Member of medical Association/Council**
6) **State the number of employees (including visiting doctors in act of the following classifications)**

1 Cont./Gen. Physician	13 Plastic Surgeon
2 Cardiologist	14 Anaesthetist
3 Neurologist	15. General Surgeon
4 Paediatrician	16. Orthopaedic Surgeon
5 Dermatologist	17. Obst.&Gynaecologist
6 Gastroenterologist	18. Eye Surgeon
7 Nephrologist	19. ENT Surgeon
8 Psychiatrist	20. Neuro Surgeon
9 Radiologist	21. CTVS Surgeon
10 Pathologist	22. Dental Surgeon
11 Nurses/Staff	23. Pharmacists
12 Trainees	24. Technicians

7) **(a) Please specify all the facilities, Available like X- ray, Scanning, pathology etc.**
   (b) Whether persons operating these are qualified and well experienced.
8) **Do you have Ambulance, if yes, specify number**
9) **Do you have Out patients departments. Please specify estimated No. of out patients to be treated in a year.**
10) **State No. of beds maintained or Designated for maternity cases.**
11) **Estimated No. of in-Patients (actual)**
    Previous year : estimated current Year to be treated in a year.

	PREVIOUS YEAR (Annual)	CURRENT YEAR (Estimated)
a) General		
b) Medical		
c) Surgical		
d) Any other class (Please specify)		

12) Give details of radioactive treatment facility. Specify the material used and precautions taken further for such usage.

13) Do you undertake training of staff
   (a) If yes, Please give details
   (b) Nature of supervision over such trainees.

14) Whether food is supplied by you to patients if yes, specify whether it is prepared by you or supplied by outsiders. If supplied by you, please specify the measures taken for maintenance of kitchen and other supervisory measures.

15) Do you supply medicines to patients ?

16) State estimated annual income (this includes Room charges, Operation theater, Rent, Charges for X - ray facilities, Doctors fees, Nursing charges, Medicines, Food, Surcharges and any other income)

17) Details of claims lodged against the proposer during the past 5 years on account of services rendered by your establishment.

18) Have you ever insured against liabilities in the past ? if so, specify the name of the insurer, policy number and period.

19) Has any insurer cancelled/ declined/ refused to renew your liability insurance or accepted your proposal subject to restrictions.

20) Details of any event likely to give rise to a liability claim against you at a future date.

21) State limits of indemnity requested of anyone year.

22) Period of insurance required
   from.....to.....

23) Voluntary Excess

I / We hereby declare that the above statement and particulars are true and I /We have not suppressed or misstated any material facts and that at the present time I / We have no reason to anticipate any claims being brought me / our for any negligent act, error or omission on my / our and against the Company and agree that this declaration shall be on the basis of the contract between me / us and the Insurer. I / We also agree that the indemnity occur in the insurance shall not be availed

For claims, arising out of acts of negligence, error or omission or misconduct committed PRIOR to Commencement of this insurance.

Date : .....

Place: ..... SIGNATURE OF PROPOSER