

# QBE MEDICAL MALPRACTICE Insurance Proposal Form for Medical Establishments



QBE Insurance (Malaysia) Berhad Reg. No.: 198701002415 (161086-D)

(Part of QBE Insurance Group)  
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)  
No. 638, Level 6, Block B1, Leisure Commerce Square, No. 9, Jalan PJS 8/9, 46150 Petaling Jaya,  
Postal Address P.O. Box 10637, 50720 Kuala Lumpur, Malaysia.  
telephone +603 7861 8400 • facsimile +603 7873 7430  
SST Reg No: B16-1808-31042744  
[www.qbe.com/my](http://www.qbe.com/my)

## Your Duty of Disclosure:

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for purposes unrelated to your trade, business or profession, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in this Proposal Form. You must answer the questions in this Proposal Form fully and accurately.

Failure to take reasonable care in answering the questions 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.

The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

In addition to answering the questions in this Proposal Form, you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

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.

Please complete information in full and check boxes tick (✓) where appropriate. Please answer on a separate sheet of paper if the space provided is insufficient.

Cover Note No.	<input type="text"/>	Intermediary No.	<input type="text"/>
Intermediary Contact Number	<input type="text"/>	Intermediary Name	<input type="text"/>
Name of Company	<input type="text"/> (Hereinafter referred to as "Company" in this Proposal and in the Policy)		
Principal Address	<input type="text"/> <input type="text"/>		
Postal Code	<input type="text"/>	Contact no	<input type="text"/>

## A. DETAILS OF APPLICANT

1. Full name of all entities to be insured (including service, administrative or nominee companies and subsidiaries that you wish to be covered by this policy):  
(Hereinafter the applicant will be referred to as "You" or "Your")

  

2. Full name of owner

3. Principal address of Establishment

  

4. Address(es) of branch offices or other locations

  

5. How long has the Establishment been operated by the present owners?

**A. DETAILS OF APPLICANT (Continuation)**

6. Please supply the following details:

Title of Staff Member	Name	Age	Qualifications	Date Qualified
Chief executive officer				
General manager				
Director of medical services				
Director of allied health services				
Director of nursing				

7. Is the Establishment duly licensed to practice at the address(es) specified in Question 3 and 4?

Yes

No

8. Please provide total numbers of employees in each of the following classifications:

(a) Surgeons	<input type="text"/>	(f) Pharmacists	<input type="text"/>
(b) Doctors	<input type="text"/>	(g) Registered nurses	<input type="text"/>
(c) Interns	<input type="text"/>	(h) Enrolled nurses	<input type="text"/>
(d) X-ray technicians	<input type="text"/>	(i) Undergraduate of student staff	<input type="text"/>
(e) Laboratory technicians	<input type="text"/>	(j) Other medical or allied health employees	<input type="text"/>
			TOTAL <input type="text"/>

**B. DETAILS OF ESTABLISHMENT**

1. 1.1 Has the name of the Establishment ever been changed?

Yes

No

1.2 Has any other establishment amalgamated or merged with you?

Yes

No

1.3 Have you purchased any other establishment?

Yes

No

If you have answered YES to either part B.1.1.1, B.1.1.2 or B.1.1.3, please supply details.

  


2. Please list the professional bodies or associations to which the Establishment belongs.

3. Does the Establishment have:

(a) an intensive care unit?

Yes

No

(b) a casualty or outpatients department?

Yes

No

(c) a radiotherapy unit?

Yes

No

(d) a medical teaching facility?

Yes

No

4. Does the Establishment operate any training school?

Yes

No

If YES, please supply details.

  


5. Do you maintain accurate descriptive records of all medical services rendered?

Yes

No

6. Do you ensure that all doctors of medicine (whether employed or visiting) who provide medical services for, or use the facilities of, the Establishment are members of a recognised medical defence union/association or protection society, or otherwise carry their own malpractice liability insurance covers?

Yes

No

**B. DETAILS OF ESTABLISHMENT (Continuation)**

7. Is there a blood banking facility?  Yes  No

If YES, please provide the following details.

- (a) (i) percentage of blood bought  %
- (a) (ii) percentage of blood collected  %
- (b) (i) approximate number of litres per annum
- (b) (ii) approximate number of plasmapheresis procedures carried out per annum
- (b) (iii) estimated annual gross receipts from the sale of the following per annum:
  - whole blood
  - blood plasma
  - serum
  - other blood products or derivatives

- (c) Please provide details of:
  - (i) the screening procedure of persons from whom blood or plasma is drawn.
  - (ii) the screening procedure of the products identified in Question 7(b)(iii) prior to their sale, use or disposal.

8. Please provide the approximate division of your patients between:

- |   |  |
|---|--|
| (a) General medical <input type="text" value=""/> %           | (i) Alcohol & other drugs <input type="text" value=""/> %  |
| (b) Surgical <input type="text" value=""/> %                  | (j) Obstetrics / maternity <input type="text" value=""/> % |
| (c) Oncology <input type="text" value=""/> %                  | (k) Neo-natal <input type="text" value=""/> %              |
| (d) Tubercular / communicable <input type="text" value=""/> % | (l) Elective cosmetic <input type="text" value=""/> %      |
| (e) AIDS / HIV <input type="text" value=""/> %                | (m) Elective terminations <input type="text" value=""/> %  |
| (f) Senile or aged <input type="text" value=""/> %            | (n) Paediatric <input type="text" value=""/> %             |
| (g) Palliative <input type="text" value=""/> %                | (o) Allied health therapy <input type="text" value=""/> %  |
| (h) Mental health <input type="text" value=""/> %             | (p) Other (please specify) <input type="text" value=""/> % |



**Grand total of all divisions above must come to 100%**

9. Please provide (A) the number of beds maintained by the Establishment (including day surgery beds)   
 (B) The number of bassinets

10. Please provide the approximate annual occupancy rate for the last financial year  %

11. Please advise number of (A) Out Patients and (B) Admitted in Patients, during last financial year  
 (A)   
 (B)

### C. FINANCIAL DETAILS

1. 1.1 Please advise the date of your financial year end:  (dd/mm/yyyy)
- 1.2 Please provide the amount of gross income/fees for the following
- (a) current financial year (estimate)
- (b) last financial year
- (c) previous financial year
2. Please provide the approximate percentage of your activities (based on gross income) applicable to each state, territory and overseas.
- | Country              | Malaysia               | Asia                   | Europe                 | USA/Canada             | Others                 |
|----------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| Percentage of income | <input type="text"/> % | <input type="text"/> % | <input type="text"/> % | <input type="text"/> % | <input type="text"/> % |

### D. CLAIMS DETAILS

1. Has any Employee of the Establishment ever been subject to disciplinary proceedings for professional misconduct?  Yes  No

If YES, please supply details.

  


2. Have any claims for malpractice been made in the last ten (10) years against the Establishment or have circumstances been notified to insurers that might give rise to a claim?  Yes  No

If YES, please supply details.

Date Matter Notified	Name of Insurer (if any)	Name of Claimant or Potential	Brief Description	Amount paid or estimate of Potential Liability	Is Matter Finalised or Outstanding

3. Is the Applicant, AFTER ENQUIRY, aware of any claim or circumstances that might give rise to a claim against the Establishment which matter is not referred to in Question D.2 above?  Yes  No

If YES, please provide the following details in respect to each matter.

Name of Claimant or Potential Claimant	Brief Description of the Matter	Estimate of Potential Liability

### E. DETAILS OF INSURANCE COVER

1. 1.1 Does the Establishment presently carry, or has the Establishment ever carried, malpractice liability insurance?  Yes  No

If YES, please supply details.

Insurer

Expiry Date

Limit of Indemnity

Premium

- 1.2 Has the Establishment ever been refused this type of insurance, or had similar insurance cancelled, or had an application of renewal declined, or had special terms imposed?  Yes  No

If YES, please supply details

  


Clear 4

## F. RISK MANAGEMENT

1. Do you have and follow documented risk management and quality control procedures?  Yes  No
2. Are these risk management procedures regularly reviewed and updated to the appropriate standards applying to your industry?  Yes  No
3. Are all appropriate staff members familiar with these procedures and/or standards?  Yes  No
4. Do you and your staff attend regular continuing education programmes that are by your Professional Association or industry bodies or groups?  Yes  No

Please provide a separate written comment to explain why a "No" answer was provided.

5. What procedures do you have for the reporting of medical incidents? Please provide full details.

## G. APPLICATION FOR COVER

1. 1.1 Limit of indemnity required
- 1.2 Deductible/Excess requested  (each and every claim)
- 1.3 Extensions:
- (i) Automatic Extensions
- |  |                        |
|--|------------------------|
| √ Libel and slander                              | Automatically Included |
| √ Loss of documents                              | Automatically Included |
| √ Coroner's enquiries                            | Automatically Included |
| √ Emergency first aid                            | Automatically Included |
| √ Students                                       | Automatically Included |
| √ Newly created or acquired entity or subsidiary | Automatically Included |
| √ Run-off cover insured entity or subsidiary     | Automatically Included |
| √ Estates and legal representatives              | Automatically Included |

## H. DECLARATION & CONSENT

I/we hereby declare that I/we have fully and accurately answered the questions in this proposal form.

Privacy Statement - I understand that the personal data provided to purchase the above insurance will be used by QBE Insurance (Malaysia) Berhad to facilitate the performance of the function as an insurance company. I allow QBE Insurance (Malaysia) Berhad to collect, use and disclose my personal data to selected third parties in or outside Malaysia, in accordance with Privacy Policy Statement which is posted at our website [www.qbe.com/my](http://www.qbe.com/my).

Proposer's Signature

Date: (dd/mm/yyyy)

**I. DECLARATION BY AGENT / BROKER / OFFICER (STAFF OF QBE)**

In compliance with Section 16(2) of the ANTI-MONEY LAUNDERING AND ANTI-TERRORISM FINANCING (AMENDMENT) ACT 2014

1. I/ WE hereby certify that I have verified and authenticated the Proposer's NRIC / Business Registration Certificate at the point of sales.
2. I/WE have maintained a copy of the NRIC of the applicants of individual insurance where premium is more than RM50,000.00, a copy of Certificate of Incorporation (ROC or ROS) for applicants of group insurance policies where premium is more than RM100,000.00.

Name

NRIC No

Signature &  
Company Stamp:

Date: (dd/mm/yyyy)