Medical Malpractice Liability
Insurance Proposal Form (Hospitals, Clinics etc)

(1) Proposer

- The name of the Hospital/ Clinic ..... Branch .....
- C.R. Number ..... Code No .....
- The parent Company or Owner(s) .....
- How long has the Hospital/ Clinic been operated by the present owners?

(2) Details of the person in charge (Administrator)

Full name ..... Title ..... Qualification .....

Years of experience ..... Tele No ..... Fax No .....

(3) The main address of the Hospital/ Clinic is:

Street ..... Town .....

Postal code ..... Tel. No .....

Fax No ..... E- mail .....

(4) If other locations are to be protected, please list them hereunder:

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(5) Is the Hospital/ Clinic duly licensed in accordance with Saudi law to practice at the addresses specified above? ☐Yes ☐No

(6) How many beds are available? .....

(7) Please state the approximate percentage of work performed:

Communicable Disease	%	Minor Surgery	%
Drug/ Alcohol Addicts	%	Intermediate Surgery	%
Geriatric / Senile	%	Major Surgery	%
Psychiatric	%	Organ Transplants	%
Pediatric	%	Elective Cosmetic Surgery	%

Other (please specify) .....

(8) Does the Hospital/ Clinic have

a) I.C.U.	☐ Yes	☐ No
b) CAT Scanners or similar	☐ Yes	☐ No
c) Medical or Nursing teaching facilities	☐ Yes	☐ No
d) Pathology Laboratories	☐ Yes	☐ No

If a Pathology Laboratory is maintained please give approximate percentages of type of analyses carried out.
Other than "in-house", laboratory services are provided to how many of the following

Hospitals ..... Doctors .....

Others (please state) .....

	Number
9) Give numbers of the following to be insured :	
a) Surgeons, Surgical Registrars`	.....
b) Physicians, Dentists, Registrars, Interns, orthopedics	.....
c) Surgical Consultants	.....
d) Non- Surgical Consultants	.....
e) Qualified Nurses	.....
f) Qualified Technicians (X-Ray/ Lab.)	.....
g) Pharmacists	.....
h) Anesthetics	

(10) Please give details of any clinics operated for out patients

a) Type of clinic .....

b) Number of employed clinic Physicians and Interns .....

c) Number of nurses .....

d) Number of patients per year .....

(11) a) Please state the amount of blood or blood products stored by your establishment at any time .....

b) Is 100% of the above bought, or obtained, from your National Blood transfusion Service, National Green Crescent Society, or the equivalent? ☐Yes ☐No

If the answer is No, please give full details of your blood banking facility .....
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c) By whom are blood or blood products tested for transmittable diseases prior to use?
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(12) State number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom treatment is given. .....
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(13) Does the Hospital/ Clinic give Radium, or other radio-active treatment? .....
If so, give details stating by whom treatment is given. .....
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(14) Has any insurance company ever cancelled, declined, refused to renew or only accepted on special terms the Proposer's malpractice Insurance? If so, give details. .....
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(15) Have claims or Suits alleging negligence, error or omission been made against the establishment or its staff, or are there any circumstance, of which you are aware, which may give rise to a claim

☐Yes ☐No

If yes please give full details including date of accident, circumstances & claim amount
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(16) Amount of insurance required:

a) any one person .....

b) in respect of all Malpractices any one period of insurance .....

(17) Who are the present insurance company of the establishment? .....

What are the present policy Limits of Liability? .....

What is the deductible ? .....

What is the expiry date of the present policy ? .....

This insurance shall be attached as soon as your proposal has been accepted by the Company and after the due contribution has been paid by you

Declaration

We declare that the statements contained in this proposal made by us (or on our behalf) are correct and true. Also, we agree that this proposal to be the basis of the insurance contract and is deemed to be incorporated therein.

Name of Hospital/ Clinic:

Official position Name : Date:

Signature