NAVIGATOR
Insurance Brokers Ltd.
Unit 8E Golden Sun Centre 223 Wing Lok St Sheung Wan HK
Tel. (852) 2530 2530 Fax (852) 2530 2535
Email: crew@navigator-insurance.com
www.navigator-insurance.com

THE NEW INDIA ASSURANCE CO. LTD.

(INCORPORATED IN INDIA WITH LIMITED LIABILITY)
6th Floor, Mancheung Building, 15-17 Wyndham Street, Central, Hong Kong
Tel: 2522 4195, 2522 4196, Fax: 2845 2133, 2845 2079, E-mail:info@newindiahk.com
(Regd. & Head Office: New India Assurance Bldg., 87, M. G. Road, Fort, Mumbai - 400 001.)
(Rated As "A - (Excellent)" By A.M. Best)

PROPOSAL FORM
DOCTORS' AND MEDICAL PRACTITIONERS' PROFESSIONAL INDEMNITY

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 there is insufficient space to answer question, please use additional sheets and attach it to this form. The Company does not assume any liabilities until the Proposal has been accepted.

1. Name of Proposer :_____

2. a) Residential address: _____

   _____

   b) Clinic address : _____

   _____

3. Professional Qualifications and the year of such qualifications:_____

4. a) Medical Registration No. _____ b) Year of Registration _____

   c) How long have you been Practicing? _____

5. Are you a member of any Medical Association/ Council? If so, please state Name and Address of such Association / Council with Membership No. _____

6. You are
   a) General Practioner/ General Physician
   b) Pathologist/Radiologist
   c) Consulting Physician
   d) Anesthetist/ Plastic Surgeon
   (If Specialist, please specify your line of specialization.) _____

7. a) Specify facilities such as dispensing facility, X-ray radiation therapy, scanning ECG, Sonography, MRI etc. available/operated by you or under your control.

   _____

   b) Are these facilities being maintained through regular service contracts with the manufacturers/ specialized serviced Agencies?

   _____

   c) If these facilities are operated by employees please state their i) names ii) technical qualification iii) experience and iv) name of the facility operated (please use separate sheet)

   d) Please indicate whether you wish to extend the policy to cover, out of the above list, personnel who are not qualified to operate the facility mentioned against their names.

8. Specify No. of employees, their job specifications, their experience and nature of your supervision.

9. a) i) Are you attached to/or attending as a visiting physician/surgeon in any Hospital/Nursing Home/Clinics etc,. If yes, please give details: _____

   b) Are they covered under a Medical Establishment-Errors & Omissions policy? _____

10. State the average number of patients you are attending per day. _____

11. Have any claims been made upon you or legal proceedings instituted or likely to be instituted against you by patients in respect of your treatment etc. If so, please give details. _____

12. Has any proposal / renewal for insurance of your Third Party liability ever been declined or special terms imposed by any Insurer in the past? Yes / No .

    Please provide details of existing Insurance Policy (if any): _____

13. Please state what limits of indemnity are required (HK$):
    For any one act _____ In aggregate during Policy Period_____

14. Policy period from _____ to _____(both dates inclusive)

I/We do hereby declare that the above statements and answers are true and what I/We have not withheld any information whatsoever regarding the proposal. I/We hereby declare that all statutory provisions relating to my/our business proposed for insurance are compiled with The New India Assurance Co. Ltd.("the Company") and I/we further agree to accept a policy subject to the usual conditions prescribed by the Company and endorsed on its policy and to pay the premium when called upon to do so. I/We undertake to exercise all ordinary and reasonable precautions for safety as if there is no insurance.

Date: _____ _____

Place: _____ Signature of Proposer & Company Chop

Personal Information collection statement :
The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of:
-Any insurance or financial related product or service or any alterations, variations, cancellation or renewal of them,
-Any claim or analysis of it ; and may be transferred to
-Any company carrying on insurance or reinsurance related business or an intermediary or a claim or investigation or other services provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed time to time.
-Any person / organization to fulfill any of the above purposes and/or for the purpose of data verification within insurance industry.
You have right to obtain access to and to request correction of any personal information concerning yourself held by Us. Request for such access can be made to the Manager of the company.

Applicable only in case Insurance Intermediary is involved:
The applicant understands, acknowledges and agrees that, as a result of the applicant purchasing and taking up the policy to be issued by The New India Assurance Company Limited, The New India Assurance Company Limited will pay the authorized insurance intermediary (Broker / agent) commission during the continuance of the policy including renewals, for arranging the said policy. Where the applicant is a body corporate, the authorized person who signs on behalf of the applicant further confirms to The New India Assurance Company limited that he or she is authorized to do so.

Insurance Broker / Agent name: _____

This form is not a policy of insurance. Please refer to the policy terms and conditions of the Policy which will be issued to you upon acceptance of your proposal.

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