Heritage Insurance Company

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Regulated by the Insurance Regulatory Authority

The Heritage Insurance Company Kenya Limited
Liberty House, Processional Way
P.O BOX 30390 - 00100, Nairobi, Kenya
(t) 254 20 278 3000 (f) 254 20 272 7800
(m) 0711 039 000, 0734 101 000
(e) info@heritage.co.ke
(w) www.heritageinsurance.co.ke

PROPOSAL FORM FOR PROFESSIONAL INDEMNITY MEDICAL MALPRACTICE LIABILITY PRACTITIONERS - (PART 2)

1. a) At what Medical School did you obtain your Qualifications? ________________________________
   b) In what year did you qualify? ____
   c) What degree did you obtain? ____
2. State whether you practice as a :(Please tick appropriate Speciality)

- ☐ Abdominal Surgeon
- ☐ Cardiologist
- ☐ Cardio-Vascular Surgeon
- ☐ General Surgeon
- ☐ Neuro-Surgeon
- ☐ Obstetrician & Gynaecologist
- ☐ Oncologist
- ☐ Opthamologic Surgeon
- ☐ Orthopaedic Surgeon
- ☐ Otorhinolaryngologist
- ☐ Pathologist
- ☐ Physician
- ☐ Physician and non-specialist Surgeon
- ☐ Plastic Surgeon
- ☐ Proctologist
- ☐ Psychiatrist
- ☐ Radiologist /Roentgenologist
- ☐ Thoracic Surgeon
- ☐ Urologist
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

3. a) Name of Partners

(For insurance purposes each Partner is required to complete a Proposal Form)

	Fullnames of Partners		Fullnames of Partners
1		6	
2		7	
3		8	
4		9	
5		10	

b) If you are the employee of a practice :

(i) What is its title? ____

(ii) Name all other employees of the corporation

	Fullnames of Employees		Fullnames of Employees
1		6	
2		7	
3		8	
4		9	
5		10	

c) If you are not the employee of a practice, please use table below to :

(i) Name all qualified Assistants (each must complete a proposal form).

(ii) Names of Nurse Anaesthetists (with qualifications).

(iii) Names of Nurse Anaesthetists (with qualifications).

(iv) Names of Other Nurses (with qualifications).

Name	Career Type	Qualifications

Name	Career Type	Qualifications

d) Do you require any of your employees to be named Insured's ? ☐ Yes ☐ No

If YES; please give details :

4. Where have you practised your profession since graduation and what year(s) ?

Practised Profession	Year (s)

5. Are you duly licensed in accordance with law to practice at the address(es) specified in Section 2 of Part 1 (Professional Indemnity General Information form). ☐ Yes ☐ No

6. Of what Professional Associations or Societies are you a member in good standing?

7. Do you advertise your business or profession :

a) other than as permitted by your National or Local Professional Association or Society ? ☐ Yes ☐ No

b) other than by an entry in the yellow pages giving only your address and telephone number? If YES; please give details: ☐ Yes ☐ No

8. State approximate division of your work and indicate if you require coverage for the following :

No.	Work	Cover Required ? (Indicate by "YES")	Percentage of Total Work Performed
1	The prescription or fitting of Contact Lenses		
2	Hypnosis		
3	The treatment of mental illness, drug addiction or alcoholism		
4	Diagnostic X-Ray procedures (other than plain X-ray)		
4-a	Angiographic procedures and Cardiac Catheterisation		
b	Administration of spinal, caudal, epidural or general anaesthesia		
5	Plastic Surgery (other than minor skin grafts)		
5- a	Traumatic		
b	Cosmetic		
Please continue to next page:			

No.	Work	Cover Required ? (Indicate by "YES")	Percentage of Total Work Performed
6	Major Surgery, which shall be defined as :		
6 -a	Orthopaedic Surgery (other than orthopaedic operations on smaller joints)		
b	Neuro-Surgery		
c	Amputation of Limbs		
d	Plating, pinning open reduction of fractures		
e	Procedures involving entry surgically or otherwise into the spine, thorax or skull		
f	Procedures involving entry surgically or otherwise in the abdomen (other than procedures concerned with normal delivery which may include episiotomy and application of low forceps).		
g	Mastectomy.		
h	Resection of facila bones and tissues		
i	Operations on the organs of the neck (other than biopsy excision of lymph nodes)		
j	Reconstructive vascular surgery and thromboembolectomy of the larger arteries and veins.		
k	Ophthalmic Surgery		
l	Mastoidectomy		
m	Operations on the inner ear		
n	Oesophagoscopy		
o	Exchange Transfusions		
7	Intermediate Surgery which shall be defined as :		
a	Tonsillectomy		
b	Adenoidectomy		
c	Closed reduction of fractures		
d	Surgical or injection treatment of varicose veins		
e	Orthopaedic operations on the smaller joints		
f	Amputation of digits		
g	Dilation and curettage.		
h	Culdoscopy		
i	Cytoscopy		
j	Gastroscopy		
k	Sigmoidoscopy		
l	Bronchoscopy		
k	Biopsy excision of lymph nodes		
m	Circumcision		
8	General Practice which in no circumstances includes any of the procedures in (7) above.		
9	Any other procedure (please describe).		

N.B. Coverage is afforded only in respect of the procedures listed in (7) above for which a specific premium has been paid and in addition for General Practice. If coverage is required for any other procedures, such procedures must be specifically declared.

11. Have you or any of your Partners, Assistants, Technicians or Nurses any physical, physiological, emotional, pathologic or psychiatric disability ? ☐ Yes ☐ No

If YES; please give details :

12. Are you engaged in any additional medical activities for which you receive payment ? ☐ Yes ☐ No
If YES; please give details :

13. Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are rendered ? ☐ Yes ☐ No
If YES; please give details:

14. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offences? ☐ Yes ☐ No
If YES; please give details:

15. Have you ever been the subject of disciplinary proceedings or reprimand by an administrative body or a professional association ? ☐ Yes ☐ No
If YES; please give details :

16. Please state amount of insurance required :

Maximum Kshs : ___________________________ inclusive of costs andexpenses.

Kshs : ___________________________ any one patient.

17. FEE INCOME

(This question must be completed accurately as the figures are used for rating purposes)

a) Please give gross fees received during the past five years :

Year	Gross Fees (Kshs.)

b) Please give the estimated fees for the coming 12 months. Kshs : _______________

CONSENT & DECLARATION

I/We consent to The Heritage Insurance Company Kenya Limited:

i. Collecting, using, disclosing, processing and/or storing my/our personal data for purposes that are relevant to my policy and as permitted by law;
ii. Collecting and sharing my personal data information in accordance with the privacy policy on its website (https://www.heritageinsurance.co.ke/): and
iii. Transferring my/our personal data to their reinsurers and affiliated companies for purposes of insurance and as permitted by law.

I/We hereby declare the truth and correctness of the above statements and particulars, and that my/our answers herein are in my/our full knowledge and have been written by me or with my full authority.
I/We hereby agree that this Proposal and Declaration shall form the basis of the contract between me/us and the Heritage Insurance Company Kenya Limited.

Proposer's Signature: ______________________________ Date:_________________________________

No liability (except for the period stated in the Insurer's Official Cover Note) is undertaken until the Proposal is accepted by the Insurer and the premium paid.