### Doctors Professional Indemnity Renewal Details / Declaration Form

1. **Policy Number**

2. **Doctor’s/ Firm Name**

   - Postal Address
   - E-mail Address
   - Telephone Number
   - Fax Number
   - PIN Number

3. **Give details of any change in professional qualifications in the last 12 months**

4. **Number of Principal Partners / Directors**

5. **Number of Qualified Assistants**

6. **Number of All Other Staff**

7. **Are you currently engaged in any additional activity for which you receive payment?**
   - YES  [ ]  NO  [ ]
   - If YES, please give details

8. **Do you currently own partly or wholly any institution that renders medical services?**
   - YES  [ ]  NO  [ ]
   - If YES, please give details

9. **Gross Fees/Earnings Received last Fiscal Year**

10. **Current Fiscal Year (Estimate)**

11. **Gross Fees / Earnings projected next Fiscal Year**

12. **Limit of Liability Required**

13. **Do you require the following extension to basic cover**
   - Dishonesty of Employees  YES  [ ]  NO  [ ]
   - Libel & Slander  YES  [ ]  NO  [ ]
   - Loss of Documents  YES  [ ]  NO  [ ]

14. **Are you aware of any circumstances or incidents which may result in a claim against you?**
   - YES  [ ]  NO  [ ]
   - If YES, please give details

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I/We hereby declare the truth and correctness of the above statements and particulars and agree that this Declaration shall be held to be promissory and the basis of the contract between me/us and The Heritage Insurance Company Limited.

**Signature**  ____________________________________________  **Date** ______________________________

**Name**  ____________________________________________

**Designation**  ____________________________________________  **STAMP**