



**PEOPLE'S INSURANCE PLC.**  
 (Company No. PB 3754)  
 No 07, Havelock Road, Colombo 05.  
 Tel: (011) 2206406 Fax: (011) 2206434

**PROFESSIONAL INDEMNITY PROPOSAL FORM FOR MEDICAL**

1. Full name of the proposer :

.....

NIC No : .....

Date of Birth :

.....

2. Address :

.....

.....

.....

..... Mobile No. : ..... Telephone No. :

.....

3. (i) At which Medical / Dental School did you qualify?

.....

(ii) In which year?

.....

(iii) Degree obtained?

.....

Please give details of any additional or postgraduate qualifications?

.....

.....

4. Period of insurance required From : ..... To :

.....

5. In what branch or branches of medicine are you qualified and licensed to practice?

Anesthesiology		Cardiology		Community Medicine	
Dermatology		Dentistry		Endocrinology	
General Practice		Genetics		Hematology	
Immunology		Industrial Health		Neurology	
Nuclear Medicine		Nutrition		Obstetrics/Gynecology	
Ophthalmology		Orthopedics		Orthodontics	
Otorhinolaryngology		Pediatrics		Pathology	
Pharmacology		Physiology		Psychiatry	
Radio therapeutics		Rehabilitation		Surgery	
Tropical Medicine		Venereology		Other (please specify)	

6. Have you been insured for Medical Malpractice or maintained membership? Yes  No  If 'YES' please state :

(i) The name of the Insurer(s) :

.....  
.....

(ii) The Insurance period/s or the period(s) :

.....  
.....

(iii) The limits of liability provided (if applicable) :

.....  
.....

(iv) Has any application for this type of Insurance cover or membership of a Defence Body ever been:

- (a) declined? YES  NO   
 (b) canceled? YES  NO   
 (c) required special terms? YES  NO

If 'YES' please give full details:

.....

7. List all claims made against the Proposer during the last 10 years, if none, please state 'NONE'.

Date of Incident	Date of Claim	Amount Claimed	Amount Paid	Amount Outstanding	Details including nature if the allegations and details of Claimant

List all circumstances / complaints which may give rise to a claim being made against the Proposer. If none, please state 'NONE'.

Date of Circumstance / Complaint	Details including nature of the Complaint and details of the Claimant

8. Please indicate the limit of indemnity you require :

(a) Per Event : .....

(b) In Aggregate : .....

9. Territorial Limit : .....

10. Jurisdiction : .....

I/We declare and warrant that after enquiry all statements and particulars contained in this Proposal are true and that no information whatever has been withheld which might increase the risk of the Insurers or influence the acceptance of this Proposal and should the above particulars alter in any way I/we will advise the Insurers as soon as practicable. I/we understand that failure to disclose any material facts which would be likely to influence the acceptance and assessment of the Proposal may result in the Insurers refusing to provide indemnity or violating the policy in every respect. I/we hereby agree and accept that this Declaration shall be the basis of the contract between me/us and Insurers upon acceptance by me/us and of the Quotation afforded by the Insurers.

Name of Proposer : (In Block Capitals)

Signature :

Date :