STMAB Medical Malpractice Takaful

Proposal Form

For Individual Healthcare Practitioners

Important Notices to the Applicants

Your Duty of Disclosure

Before you enter into a contract of general Takaful with the Takaful Operator, you have a duty to disclose to the Takaful Operator every matter within your knowledge that is material to the Takaful Operator's decision whether to accept the risk of the Takaful and, if so, on what terms.

You have the same duty to disclose those matters to the Takaful Operator before you renew, extend, vary or reinstate a contract of general Takaful.

It is important that all information contained in this application is understood by you and is correct, as you will be bound by your answers and by the information provided by you in this application. You should obtain advice before you sign this applicaton if you do not properly understand any part of it

Your duty of disclosure continues after the application has been completed up until the contract of Takaful is entered into.

Non-Disclosure:

If you fail to comply with your duty of disclosure, the Takaful Operator may have the option of avoiding the contract of Takaful from its beginning.

If your non-disclosure is fraudulent, the Takaful Operator may also have the right to keep the premium that you have paid.

Change of Risk or Circumstances:

You should advise STMB as soon as practicable of any change to your normal business as disclosed in this application, such as changes in business activities, location, acquisitions and new overseas activities.

Subrogation

Where you have agreed with another person or company (who would otherwise be liable to compensate you for any loss or damage which is covered by the contract of Takaful) that you will not seek to recover such loss or damage from that person, STMB will not cover you, to the extent permitted by law, for such loss or damage.

Instructions to the Applicant

A. This form is intended for individual healthcare practitioners. These include, but are not limited to, physicians, surgeons, dentists, pharmacists, physician assistants, nurses and other allied health and therapeutic care practitioners.
B. You must answer **all** the questions in this form. If a question is not applicable, state **"N/A"**. If more space is required to answer a question, continue on your letterhead.
C. If you are a new practice, use the projected figures from your business plan.
D. If you have any questions concerning this proposal, please contact your Takaful broker or adviser to discuss.

Application for Takaful Cover

Period of Takaful	From :	To :
Limit of Liability Required	:	
Premium	:	
Excess/Deductible Requested	:	
Retroactive Date	:	

1. Details of Applicant

1.1	Name	:	
1.2	Identity Card No. (IC No.)	:	DOB :
1.3	Gender	Male ☐	Female ☐
1.4	Primary practice address	:	
	Correspondence address	:	
1.5	Are you duly licensed to practice at the address(es) specified?	Yes ☐	No ☐
1.6	Contact phone number	:	
1.7	Email address	:	

1.8 Please indicate your qualification(s):

Institution	Degree or Qualification / Specialty	Year Obtained

1.9	Please provide the details of your registration below :	
	(a) Licensing / Registration Body	:
	(b) Registration Number	:
	(c) Registration Date	:
	(d) Date of first Registration	:
1.10	Other Registration Details (where applicable),	

1.11	Please list any medical societies & associations you are a member of :		
1.12	Have you ever had any of the above declared in questions 1.9, 1.10, 1.11 refused, suspended, withdrawn or had conditions imposed at any time? If YES, please provide details on a separate sheet, noting the Section number.	Yes ☐	No ☐

2. Details of Healthcare Services Business

2.1 Please indicate your classification and volume of work performed below:

Specialisation	**%**	**Specialisation**	**%**
Doctor			
Anaesthesiology		General Practitioner	
Cardiology		Ophthalmology (including LASIK & laser)	
Dermatology		Paediatrics (no surgery)	
Dentist – Cosmetic Dentistry		Psychiatry	
Dentist - Employer Indemnified		Radiology	
Dentist – Endodontist / Periodontist / Prosthodontist		Other (please specify):	
Dentist – General Dentistry			
Gastroenterology		**Total**	100%

Surgeon			
Bariatric Surgery		Oncology	
Cardiothoracic Surgery		Oral Maxillofacial Surgery	
Ear/Nose/Throat		Orthopaedic Surgery	
General Surgery		Paediatric Surgery	
Gynaecology		Plastic Surgery (elective / cosmetic)	
Hand Surgery		Plastic Surgery (reconstructive)	
Neurosurgery		Other (please specify):	
Obstetrics/maternity		**Total**	100%

Allied Health & Ancillary Staff			
Counsellor		Optometrist	
Chinese Medicine Practitioner		Osteopath	
Chiropractor		Pharmacist	
Dental Assistants - Therapist, Hygienist, Technician		Physiotherapist	
Diagnostic Radiographer		Podiatrist	
Healthcare Assistant/Worker		Psychologist	
Massage Therapist		Therapist Aide	
Midwife		Other (please specify):	
Nurse			
Occupational Therapist		**Total**	100%

2.2 Please provide details of your income and patient numbers:

	Year	**Income**	**Number of Patients**
	Current year (est.)	MYR	
	Past year	MYR	

2.3	Do you provide healthcare services in your host country only? If NO, please provide the breakdown of overseas services below:			Yes ☐	No ☐

Year	Country	Income	Number of Patients
Current year (est.)		MYR	
Past year		MYR	

3. Risk Management

3.1	Do you maintain accurate and descriptive records of all medical services rendered, and equipment used in procedures?	Yes ☐	No ☐
3.2	Is informed consent obtained from each patient and documented in their medical record? If NO, how often is informed consent obtained?	Yes ☐	No ☐
3.3	Do you have facilities for sterilisation of instruments in accordance with relevant guidelines/standards applying to your industry?	Yes ☐	No ☐
3.4	Do you have a written procedure for the reporting of incidents and adverse events?	Yes ☐	No ☐

4. Takaful/Insurance History

4.1 Do you currently hold medical malpractice Takaful/Insurance? Yes ☐ No ☐
If YES, please provide details.

Period of Takaful/Insurance	Takaful Operator/Insurance	Certificate Limit (RM)	Excess (RM)	Retroactive Date

4.2 Have you ever had any application for medical malpractice Takaful/Insurance refused, or had any medical malpractice Takaful coverage rescinded or cancelled? Yes ☐ No ☐

If YES, please provide details on a separate sheet, noting the Section number.

5. Claims Experience

5.1	Have any claims ever been made, or lawsuits been brought against you?	Yes ☐	No ☐
5.2	Are you aware of any errors, omissions, offences, circumstances or allegations which might result in a claim being made against you?	Yes ☐	No ☐
5.3	Have you ever been the subject of disciplinary action or investigation by any authority or regulator or professional body?	Yes ☐	No ☐
5.4	Have you ever been the subject of a criminal investigation or had criminal charges brought against you? For the purposes of this question, please disregard traffic or minor motor vehicle licensing offences.	Yes ☐	No ☐

If you had answered Yes to any of the questions in this section, please **provide full details overleaf** and the **status** of each claim, lawsuits, allegation or matter, including

- the date of the claim, suit or allegation
- the date you notified your previous Takaful Operators
- the name of the claimant(s) and the services rendered
- the allegations made against you
- the amount claimed by the claimant(s)
- whether the status is outstanding or finalised
- the amounts paid for claims and defence costs to date

Declaration & Signature

- I have read and understood the Important Notices contained in this application.
- I agree that this proposal, together with any other information or documents supplied, will form the basis of any contract of Takaful.
- I acknowledge that if this application is accepted, the contract of Takaful will be subject to the terms and conditions as set out in the certificate wording as issued or as otherwise specifically varied in writing by STMB.
- I declare, **after inquiry**, that the statements, particulars and information contained in this application and in any documents accompanying this application are true and correct in every detail and that no other material facts have been misstated, suppressed or omitted.
- I undertake to inform STMB of any material alteration to those facts before completion of the contract of Takaful.
- We understand that STMB needs to deal with our personal data to administer our Policy and offer us Takaful products and services. To achieve these purposes, We allow STMB to collect, use and disclose our personal data to selected third parties in or outside Malaysia, in accordance with STMB's Personal Data Protection Notice, which is found in STMB website at http://www.takaful-malaysia.com.my. We may contact STMB for access to or correction of our personal data, or for any other queries or complaints. / *Kami faham bahawa STMB perlu berurusan dengan data peribadi kami untuk mentadbir Polisi kami dan menawarkan kami produk dan perkhidmatan insurans. Untuk mencapai tujuan-tujuan ini, kami membenarkan STMB untuk mengumpul, mengguna dan memberi data peribadi kami kepada pihak ketiga terpilih yang terletak di dalam atau di luar Malaysia, selaras dengan Notis Perlindungan Data Peribadi STMB, yang terdapat dalam laman web STMB di* http://www.takaful-malaysia.com.my. *Kami boleh menghubungi STMB untuk mendapatkan atau membetulkan data peribadi kami, atau untuk sebarang pertanyaan atau aduan.*

This form **must** be reviewed, signed and dated by a duly authorised Principal, Partner or Director. The authorised person who signs on behalf of the Proposer further confirms to STMB that he or she is authorised to do so.

Signature :	**Title of signatory & Stamp :** **Date :**

Third Party Verification,

Signature	**:**
Name	**:**
Agency Code	**:**
Date	**:**