STMAB Medical Malpractice Takaful

Proposal Form

For Medical Establishment

Important Notices to the Applicants

Your Duty of Disclosure

You have the duty to disclose to Syarikat Takaful Malaysia AM Berhad ("STMAB", "Us", "We" or "Our") any matter that:

(a) You know to be relevant to Our decision on whether to accept the risk or not and the rates and terms to be applied; or
(b) a reasonable person in the circumstances could be expected to know to be relevant.

You have the same duty to disclose those matters to Us 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.

You duty of disclosure continues after the application has been completed up until the contract of insurance is entered into, varied or renewed.

Non-Disclosure:

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

If your non-disclosure is fraudulent, We may also have the right to keep the contribution that you have paid.

Change of Risk or Circumstances:

You should advise Us 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 policy, that you will not seek to recover such loss or damage from that person, STMAB 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 health facilities. These include hospitals, clinics, outpatient care centres and specialised care.
B. This proposal **must be completed, signed and dated by a Principal, Partner or Director**.
C. You must answer **all** the questions in this form. If a question is not applicable, state **"N/A"**. If more spae is required to answer a question, continue on your letterhad.
D. If you are a new business, use the projected figures from your business plan.
If you have any questions concerning this proposal, please contact your takaful broker or adviser to discuss.

Application for Insurance Cover

Period of Takaful	From :	To :	
Limit of Liability Required	Option 1 MYR :	Option 2 MYR :	
Excess/Deductible Requested	Option 1 MYR :	Option 2 MYR :	
Type of Takaful Requested	☐ Takaful	☐ Retakaful	
Are you requesting cover for Fraud & Dishonesty?		Yes ☐	No ☐
Are you requesting cover for Cyber and Privacy Infringement Liability?		Yes ☐	No ☐

Details of Applicant

1.1 Names and company Registration Numbers of all practice entities applying to be covered under this takaful (Referred to as "You" in the rest of this form).

:

1.2	Has your name ever been changed, or have you purchased or merged with any other practice or business? If YES, please attach details.	Yes ☐	No ☐

1.3 Please list your principal address.

:

1.4 Please list the address(es) of your branch offices or other locations (if applicable).

:

1.5 What is your website address?

:

1.6 When was your practice entity established?	: (day)	: (month)	: (year)

1.7 Please indicate:

Type of Facility		**Nature of practice entity**
☐ Private Hospital	☐ Retirement Village	☐ Joint Venture
☐ Public Hospital	☐ Rehabilitation Centre	☐ For profit
☐ Hospital - Other	☐ Hospice	☐ Not for profit
☐ Clinic	☐ Laboratory	☐ Limited Liability Company
☐ Group Practice	☐ Pharmacy	☐ Limited Partnership
☐ Nursing Home		

1.8 Please indicate the number of personnel applicable below:

Classification	**P/T**	**F/T**	**Classification**	**P/T**	**F/T**
Principals, partners or director			X-ray technicians		
Doctors (including locum doctors)			Physiotherapists		
Surgeons			Midwives		
Interns			Healthcare assistance / health workers		
Registered Nurse			Other registered professionals		
Enrolled nurses			Other skilled & technical employees		
Pharmacists			Non-technical administrative staff		
Laboratory technicians			Other staff (pease specify)		
Dentist			Total		

1.9 What are the qualifications of your Principals, Partners, Directors or other key professional personnel?

Name	Qualifications	Year Qualified	Years as Principal, Partner or Director	
			This practice	Previous practice

1.10 If there is only a sole Principal, what arrangements do you have in place to ensure business continuity when that Principal is travelling, on leave, ill or away from the office ?

2. Details of Business

2.1 Which professional societies & associations are you, your Principals, Partners or Directors member of?

2.2	Is your practice entity duly licensed to practice at the address(es) specified in Questions 1.3 and 1.4?	Yes ☐	No ☐
2.3	Do you ensure that all doctors providing medical services for or using the facilities of your firm are members of a Medical Defense Union or Medical Protection Society or otherwise carry their own medical malpractice takaful covers?	Yes ☐	No ☐
	If NO, are you requesting coverage for these doctors as part of your application?	Yes ☐	No ☐
2.4	Are you ISO 9001 certified? If YES, when was this achieved and for which activities?	Yes ☐	No ☐

2.5	What is the total number of beds:	

2.6	What is the average annual occupancy rate of beds:	
2.7	What is the total number of bassinets:	
2.8	What is the average annual occupancy rate bassinets:	
2.9	What is the total number of patients annually:	(i) Outpatients (ii) Inpatients

2.10 Do you have an:

(i)	Intensive care unit (ICU)?	Yes ☐	No ☐
(ii)	Accident & emergency (A&E) department?	Yes ☐	No ☐
(iii)	Outpatients department?	Yes ☐	No ☐
(iv)	Medical teaching facility?	Yes ☐	No ☐
(v)	Pathology facility?	Yes ☐	No ☐
(vi)	Blood banking facility?	Yes ☐	No ☐

Helipad Liability

2.11	Do you own or operate a heliport or helipad? If NO, please disregard the remaining questions in this section.	Yes ☐	No ☐
a)	Number of annual landings:		
b)	Where are the heliports/helipads located?	☐ Lawn ☐ Roof ☐ Carpark ☐ Other (Please specify) :	
(c)	Is the helicopter landing pad approved by the governing aviation authority?	Yes ☐	No ☐
(d)	Is the medical team comprised of certified and experienced retrieval medicine physicians and registered nurses with critical care and emergency nursing experience? If NO, please provide details on a separate sheet.	Yes ☐	No ☐

2.12 What percentage of your activities are represented by each of the following of professional healthcare services:

Type of services	**%**	**Type of services**	**%**
Audiology		Oncology	
Aged Care/Assisted Living		Ophthalmology (including LASIK & laser)	
Cardiology		Paediatrics	
Communicable Disease/Tubercular		Pathology	
Dentistry		Physiotherapy	
Dermatology		Plastic surgery (elective cosmetic)	
Drug/alcohol dependency		Plastic surgery (reconstructive)	
Ear/Nose/Throat		Podiatry	
Elective Termination		Psychiatric	
Gastroenterology		Radiography/medical imaging	
General Practice/General Medicine		Rehabilitation	
Gynaecological		Surgical	
In vitro fertilisation (IVF)		Traditional medicine	
Obstetrics/maternity		Other Please specify :	
		Total	100%

2.13 Do you engage in any other professional healthcare services or business activities other than what is described in this section? If YES, please attach details of the type of work and the fee income from these other activities.	Yes ☐	No ☐
2.14 Are you or any of your Principals, Partners or Directors connected or associated with any other practice or business?	Yes ☐	No ☐

3. Details of Business

3.1	When does your Financial Year end?	..... (day)	..... (month)

3.2 What is your total turnover or fee income for the:

	Year	Malaysia	Total
Coming year (est.)	:	MYR :	MYR :
Current year (est.)	:	MYR :	MYR :
Past year	:	MYR :	MYR :

3.3 Please indicate your patient demographic:

Malaysia	Other Asia	Australia/NZ	Europe	USA/Canada	Others	Total
%	%	%	%	%	%	100%

3.4 Please list the foreign countries you provide services in and the number of staff located in each:

Country	Number of staff	Country	Number of staff

4. Risk Management

4.1	Do you keep accurate records and ensure all medical professionals hold valid licenses to practice in their respective specialisations issued by the relevant official authority in the country where your practice?	Yes ☐	No ☐
4.2	Do you maintain accurate and descriptive records of all medical services rendered, and equipment used in procedure?	Yes ☐	No ☐
4.3	Do you have facilities for sterilisation of instruments in accordance with relevant guidelines/standards applying to your industry?	Yes ☐	No ☐
4.4	Do you have and follow documented risk management and quality control procedures?	Yes ☐	No ☐

4.5	Are these risk management and quality control procedures regularly reviewed and updated to the appropriate standards applying to your industry?	Yes ☐	No ☐

5. Insurance/Takaful History

5.1 Do you currently hold insurance / medical malpractice takaful? Yes ☐ No ☐
If YES, please provide details.

Period of Takaful/Insurance	Takaful/Insurance Operator	Certificate Limit	Excess	Retroactive Date
		MYR	MYR	

5.2 Have you ever had any application for insurance/medical malpractice takaful refused, or had any insurance/medical malpractice takaful coverage rescinded or cancelled? Yes ☐ No ☐

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

6. Cyber and Privacy Infringement Liability

(Only complete this section if you request cover for Cyber and Privacy Infringement Liability Extension)

6.1	Do you have a formal certificate to segment sensitive data?	Yes ☐	No ☐
6.2	Do you encrypt sensitive personal data [including Protecded Infomation (PHI) and Electronic Medical Record (EMR)] anywhere that is stored, transmitted and/or on mobile devices?	Yes ☐	No ☐
6.3	Do you currently carry or are you in the process of applying for D&O or Cyber/Privacy Coverage?	Yes ☐	No ☐
6.4	Do you have a person dedicated for Information Security?	Yes ☐	No ☐
6.5	Do you have a Written Information Security Program (WISP)?	Yes ☐	No ☐
6.6	Have you taken all necessary steps to ensure compliance with the Personal Data Protection Act 2010 and/or any similar law or regulation in any other jurisdiction which governs the collection, use, processing, handling, storage, disclosure or transfer of personal/sensitive data?	Yes ☐	No ☐
6.7	Have you undergone an Information Security Audit?	Yes ☐	No ☐
	If YES, what is the date?		
	If YES, is the result satisfactory? Please describe:		

7. Claims Experience

7.1	Have any claims ever been made, or lawsuits been brought against you, your predecessors in business, or any current or former Principals, Partners, Directors, employees, or any other person or entity applying to be covered under this proposed contract of takaful?	Yes ☐	No ☐
7.2	Are any of the Principals, Partners, Directors or employees aware, **after inquiry**, and as of the date of signing this application, of any errors, omissions, offences, circumstances or allegations which might result in a claim being made against you or any person or entity applying to be covered under this proposed contract of takaful?	Yes ☐	No ☐
7.3	Have you, your predecessors in business, or any current or former Principals, Partners, Directors, or employees ever been the subject of disciplinary action or investigation by any authority or regulator or professional body?	Yes ☐	No ☐

If you had answered Yes to any of the questions in this section, please **provide full details** 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 operator
- the name of the claimant(s) and the establishment(s)
- 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

Additional Information to Send with Your Application

Attach a copy of the following:	**Included?**	
Corporate profile, brochures, pamphlets, or other marketing material describing your operations and services	Yes ☐	No ☐
Standard contracts or service agreements with clients or patients	Yes ☐	No ☐
Resumes or CVs of all your Principals, Partners or Directors	Yes ☐	No ☐
For new business only, your business plan with projections of business	Yes ☐	No ☐

Declaration & Signature

- We have read and understood the Important Notices contained in this application.
- We agree that this proposal, together with any other information or documents supplied, will form the basis of any contract of takaful.
- We acknowledge that if this application is accepted, the contract of insurance 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 STMAB.
- We 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.

- We undertake to inform STMAB of any material alteration to those facts before completion of the contract of takaful.
- We understand that STMAB needs to deal with our personal data to administer our Certificate and offer us takaful products and services. To achieve these purposes, We allow STMAB to collect, use and disclose our personal data to selected third parties in or outside Malaysia, in accordance with STMAB's Personal Data Protection Notice. We may contact STMAB for access to or correction of our personal data, or for any other queries or complaints. / *Kami faham bahawa STMAB perlu berurusan dengan data peribadi kami untuk mentadbir Sijil kami dan menawarkan kami produk dan perkhidmatan insurans. Untuk mencapai tujuan-tujuan ini, kami membenarkan STMAB 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 STMAB. Kami boleh menghubungi STMAB 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 STMAB that he or she is authorised to do so.

Signature:	**Title of signatory:** **Date:**