

GEMINIA INSURANCE COMPANY LIMITED

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**PROFESSIONAL INDEMNITY &
MEDICAL MALPRACTICE
PROPOSAL FORM**
(CLINICAL OFFICERS - KCOA MEMEBERS ONLY)

INSTRUCTIONS:

- Please read carefully and fill out the entire document.
- All questions must be answered in full, in BLOCK letters in the applicants own handwriting or dictation.
- Submit a Certificate of Incorporation, KRA pin certificate with this application.

Part 1. Proposer's Details

Full name of the proposer: _____

KRA Pin No _____ (Please attach a copy of the certificate)

National ID/Passport No: _____ (Please attach a copy of ID/Passport)

Postal Address: _____

Email Address: _____

Location of the premises: _____

Contact person's mobile number: _____

How long have you conducted the business in terms of years? _____

Period of Insurance From: _____ To: _____

Name of intermediary _____

Business/Employers name (Hospital): _____

At what medical school did the proposer graduate _____

Year of graduation _____

Is the proposer duly licensed in accordance with the law to practice? Yes No (Please attach a copy of the license)

Is the proposer a member of any professional association? Yes No

If yes, provide the registration number _____

Provide the name of the professional association _____

Is the proposer a member of any specialty association? Yes No

If yes, provide the registration number _____

Provide the name of the association's specialty _____

Part 2: Details of Insurance

a. Specify your area of medical specialization _____

b. Does the proposer own, wholly, or in part operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____

If so, please give the following details;

i) The number of reserved beds. _____

i) Give details of staffing _____

ii) The number of patients per year? _____

c. Has the proposer had any previous claims or any liability cases pending in court

If so, give full details _____

d. What is your proposed limit of cover (Limit of Indemnity) Ksh _____ (any one claim/year)

e. Details of Beneficiary				
Name of Kin	Relationship with the Insured	Percentage of Benefit	Date of Birth	Contact Telephone/Cell

Part 3 General Insurance History

a. Are you currently insured in respect of the above risks?

If yes state: Insurance Company _____ Expiry Date _____

b. Has any Insurer

i) Declined to insure you? Yes No

ii) Required special terms to insure you? Yes No

iii) Cancelled or refused to renew your insurance? Yes No

iv) Or increase your premium on renewal? Yes No

Part 4 Declaration

I/We do hereby declare that to the best of my knowledge and belief that the statements set forth herein are true and complete. Further, no material facts have been missed or misrepresented. I/we agree that the proposal together with any other information supplied shall form the basis of any contract of insurance effected thereon.

Name of person Completing the Proposal form _____

Designation _____ Date _____

Signature _____

NOTE:

- 1. The Insured shall accept a policy subject to excesses, restrictions, terms & conditions Geminia Insurance Company Limited may deem necessary.
- 2. The Insured undertakes to inform the insurer of any material alteration whereby the risk has increased and the insurer reserve the right to modify the terms of the policy.