

Medical Malpractice Proposal Form for the members of the Medical Association of Malta

IMPORTANT NOTE

Please read the following guidelines before completing this Proposal Form. Where further information or clarification is required, please refer to our offices or to your Insurance Broker or Insurance Salesperson.

It is important to note that this Proposal Form is for indemnification on a CLAIMS MADE BASIS. This Policy will only respond to "Claims" made against the Proposer and notified to Insurers during the period of insurance.

- A. This proposal must be fully completed, signed and dated by the person (The Proposer) seeking the quotation for Medical Malpractice Insurance. Please answer every question fully and state "NIL" or "NONE" as applicable. Unless the Proposal is fully completed a final quotation cannot be given. The completion and signature of the Proposal does not bind the Proposer or Insurers to complete a Contract of Insurance.
- B. It is the duty of the Proposer to disclose all material facts to Insurers. Where this is omitted, the Insurers may avoid their obligations under the Policy. A material fact is one that is likely to influence an Insurer's judgment and acceptance of your Proposal.
- C. Please submit any additional information you feel may be of assistance to Insurers.
- D. Upon acceptance of Insurers' terms and conditions and payment of the premium, all information provided by the Proposer together with these guidelines will be deemed to be incorporated in the contract between Insurers and the Proposer.
- E. Copies of Proposal Forms should be retained for your own records.

ALL QUESTIONS MUST BE FULLY ANSWERED

SECTION A - PROFESSIONAL INDEMNITY

1. APPLICANT DETAILS (PLEASE USE CAPITAL LETTERS)

Title	Name & Surname of Proposer	
MAM Registration Number		
ID Card Number	Date of Birth	
Passport Number	Place of Issue	Date of Issue
Nationality		
Gender	Marital Status	
Contact Number	Email Address	
Business Address		
Please state your original number of registration and the date of registration		

2. NATURE AND VOLUME OF YOUR PRESENT AND FORESEEABLE FUTURE ACTIVITIES

In what branch or branches of medicine are you qualified and licensed to practice	
a) Anesthesiology	YES <input type="checkbox"/> NO <input type="checkbox"/>
b) Cardiology	YES <input type="checkbox"/> NO <input type="checkbox"/>
c) Dermatology i) Dermatologist Surgeon ii) Dermatologist (All Others)	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
d) Dentistry i) Orthodontist Dental Surgeon ii) Oral Surgeon iii) Dental Technologist & Dental Hygienist	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
e) ENT Specialists	YES <input type="checkbox"/> NO <input type="checkbox"/>
f) General Practitioner	YES <input type="checkbox"/> NO <input type="checkbox"/>
g) General Surgery	YES <input type="checkbox"/> NO <input type="checkbox"/>
h) Geriatricians	YES <input type="checkbox"/> NO <input type="checkbox"/>
i) Haematology	YES <input type="checkbox"/> NO <input type="checkbox"/>
j) Internal Medicine	YES <input type="checkbox"/> NO <input type="checkbox"/>
k) Neurology	YES <input type="checkbox"/> NO <input type="checkbox"/>
l) Nurses	YES <input type="checkbox"/> NO <input type="checkbox"/>
m) Obstetrics and Gynaecology	YES <input type="checkbox"/> NO <input type="checkbox"/>
n) Oncology	YES <input type="checkbox"/> NO <input type="checkbox"/>
o) Ophthalmology	YES <input type="checkbox"/> NO <input type="checkbox"/>
p) Orthopaedics	YES <input type="checkbox"/> NO <input type="checkbox"/>
q) Paediatric i) Paediatric Surgeon ii) Paediatric (All Others)	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
r) Pathology	YES <input type="checkbox"/> NO <input type="checkbox"/>
s) Plastic Surgery	YES <input type="checkbox"/> NO <input type="checkbox"/>
t) Podiatry i) Podiatric Surgeon ii) Podiatric Physician	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
u) Psychiatry	YES <input type="checkbox"/> NO <input type="checkbox"/>
v) Radiology i) Radiologist ii) Radiographer	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
w) Urology	YES <input type="checkbox"/> NO <input type="checkbox"/>
x) Any other, not shown If so, please specify:	

At what medical school did you graduate and year of Graduation?	
Please state the degree obtained and give any details of any post graduate qualifications where applicable.	
Where and when has the proposer practised his profession since graduation?	
Is the proposer duly licenced in accordance with law to practice at the business address mentioned above?	
Member of association? If yes, please give details.	

Is the Proposer, Partner or Assistant regularly involved in first-aid service?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Name(s) of Partners (For each partner all questions listed above have to be answered individually)	
Name(s) of qualified medical assistant(s)	
Number of technicians employed	
Number of nurses employed	
Is the Proposer under contract with or in the employment of any individual, firm or cooperation? If so, please give details.	YES <input type="checkbox"/> NO <input type="checkbox"/>
Does the Proposer own, wholly or in part, operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? Does he have any reserved beds there? If so, please give details including number of reserved beds	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
Does the Proposer own or operate X-ray machines or laser? If so, please give number, type and whether they are used for diagnosis or treatment or both.	YES <input type="checkbox"/> NO <input type="checkbox"/>
Number of patients per year	
Please give full details of what patient records are kept and where and how they are stored	
Please state the fees earned (private practice only) for the previous two years and projected fees for this year	

3. PREVIOUS INSURANCE/ PREVIOUS CLAIMS

Has the Proposer previously been insured? YES <input type="checkbox"/> NO <input type="checkbox"/>																					
If so, please specify:																					
	<table><thead><tr><th></th><th>Name of Insurer</th><th>Policy Period</th><th>Limit of indemnity</th></tr></thead><tbody><tr><td>1</td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td></tr></tbody></table>		Name of Insurer	Policy Period	Limit of indemnity	1				2				3				4			
	Name of Insurer	Policy Period	Limit of indemnity																		
1																					
2																					
3																					
4																					
Has a previous application been declined? Has a previous insurance a) required increased premium? b) required special restrictions? c) been terminated/not been renewed by an insurer? If so, please give detailed information.	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>																				
Have any claims or suits for malpractice been made against the Proposer or any of his partners, assistants, nurses or technicians during the past five years? If so, please advise amount and details of each claim	YES <input type="checkbox"/> NO <input type="checkbox"/>																				
Is the Proposer or any of his partners, assistants, nurses or technicians aware of any circumstances, incidents or losses which may result in a claim? If so, please give details.	YES <input type="checkbox"/> NO <input type="checkbox"/>																				
Have you as the proposer, or any of your partners, assistants, nurses or technicians ever been convicted or charged but not yet tried for any offence? If Yes, please give details	YES <input type="checkbox"/> NO <input type="checkbox"/>																				

4. INDEMNITY REQUIRED

Cover a) Indemnity required Please indicate the limit any one claim Option A - €100,000 Option B - €200,000 Option C - €250,000	
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5. ENDORSEMENTS TO BASIC COVER

Do you require Retroactive Cover?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If so, indicate number of years (maximum number of years – 5 years)	
Libel and Slander	YES <input type="checkbox"/> NO <input type="checkbox"/>
Loss of Document	YES <input type="checkbox"/> NO <input type="checkbox"/>
Dishonesty of Employees	YES <input type="checkbox"/> NO <input type="checkbox"/>

SECTION B - HEALTH INSURANCE

The purpose of the policy is to provide cover for the customary and reasonable fees of recognised treatment, which is medically necessary for Major acute medical conditions (as defined in the policy) carried out either due to an emergency on a non-elective basis during temporary business or holiday trips abroad or, in the case of elective treatment abroad, only in respect of treatments which are not available in Malta and with the prior agreement of the Company. All claims for treatment carried out in Malta are excluded from cover.

What is your principal country of residence? (wherein you reside for more than 180 days In any 12 month period)					
Would you like to extend cover to include your dependants? (all persons must reside at the applicant's address unless agreed otherwise)					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
	Name	Surname	Date of Birth	ID Card Number	Relationship to the Proposer
Dependent 1					
Dependent 2					
Dependent 3					
Dependent 4					
Are you or any dependant/s listed in this Proposal Form residing away from the principal country of residence for more than 180 days in any 12 month policy period? If Yes, please give details.					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
Medical History and Other Information Please ensure that you disclose all known and suspected medical conditions in respect of any person to be included in this Proposal Form. It is important to note that we shall not accept liability for a medical condition which arose prior to the proposal date unless such a condition is declared and which MAPFRE Middlesea plc did not exclude. Failure to notify MAPFRE Middlesea plc of any suspected medical condition may result in the policy being invalidated.					

Have you or any of your dependants included in this Proposal Form:

a. Consulted with a general practitioner/family specialist and been provided with prescription drugs or medication within the last five years?	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Consulted with a specialist in the last five years with an actual or suspected medical condition?	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Is there any known or foreseeable need to consult a doctor or any other health professional for any reason?	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Been admitted to a hospital, clinic or nursing home in the last five years?	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. Currently taking any medication or is there any foreseeable need to take medication?	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Do you undergo regular check ups (such as, but not limited to: mammograms, colonoscopy, bone density, pap smear, ECG, cholesterol, prostate check ups)? If yes, please provide us with a copy of the most recent results.	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Do you suffer from a chronic medical condition, or from a known disability, or recurrent injury or illness (such as but not limited to: hypertension, diabetes, asthma, recurrent injury)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Been refused Private Medical Insurance or Life Assurance Cover?	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. Are you or any of your dependants currently insured or was/were insured under another Private Medical Insurance policy? If yes, please provide details.	YES <input type="checkbox"/> NO <input type="checkbox"/>
j. Do you or any of your dependants included in this Proposal Form smoke? If yes, indicate who smokes, for how long has he/she been smoking and how many cigarettes he/she smokes daily.	YES <input type="checkbox"/> NO <input type="checkbox"/>

If you have answered 'YES' to any question from a-j please give full details in the space provided

Question Number	Name and Surname	Medical Condition	Date of Diagnosis	Treatment Received	Does this medical condition still exist

Additional Comments (include any other facts that should be brought to our attention)	
Name and address of your usual family GP/Family Specialist	

SECTION C - PERSONAL ACCIDENT

SCALE OF COMPENSATION

Death:	€10,000
Permanent Total Disablement:	€10,000
Permanent Partial Disablement:	€10,000 – according to Permanent Disability Scale
Temporary Total Disablement (Accident and Sickness):	€150 per week up to a maximum of 104 weeks for Accident Claims and up to a maximum of 52 weeks for sickness claims
Medical Expenses	Nil
Are you to the best of your knowledge and belief in sound physical and mental health and free from any physical defect or infirmity? If not, give details	YES <input type="checkbox"/> NO <input type="checkbox"/>
Has any person to be insured sustained any accidents during the past five years? Is so, give details	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you, or do you intend to participate in any hazardous occupation, pursuits or hobbies e.g. aviation, motorsports, working at heights above 30 feet, fireworks manufacture, extreme sports or diving? If so, give details.	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you now or have you ever been insured for these risks? If so, give details:	YES <input type="checkbox"/> NO <input type="checkbox"/>

IMPORTANT

You should not sign this Proposal Form and its statements or declarations before you have read and understood them. If this document is being completed by someone else on your behalf please ensure that the details on it accurately reflect what you have said.

APPLICABLE LAW

Unless both you and we agree otherwise this contract shall be subject to Maltese Law and to the exclusive jurisdiction of the Maltese courts.

INSOLVENCY

In the event that we become insolvent and unable to meet our obligations under this contract, limited compensation may be available to you under the Protection and Compensation Fund Regulations, 2003.

COMPLAINTS

We are committed to providing good quality services. We recognise that a client may not be satisfied with the service provided. To deal with this we have a complaints procedure. For the sake of clarification, a complaint is broadly defined as being a written expression of dissatisfaction with services that we provide or actions we have taken that require a response.

HOW TO COMPLAIN

STEP 1 – CONTACTING THE COMPANY

The first step is to talk to a member of our personnel or of the intermediary if the Policy was arranged through one. This can be done informally either directly or by telephone.

Usually the best person to talk to will be the person who dealt with the matter you are concerned about as they will be in the best position to help you promptly and to put things right. If they are not available or you would prefer to approach someone else then address the matter to the manager or senior person responsible. We will seek to resolve the problem immediately. If we cannot

do this then we will take a record of the concern and arrange the best way and time for getting back to you. This will normally be within two working days.

STEP 2 – TAKING THE COMPLAINT FURTHER

If you are still unhappy, the next step is to put the complaint in writing, addressing it to Complaints Officer, MAPFRE Middlesea plc, Middle Sea House, Floriana FRN 1442 or via e-mail on compofficer@middlesea.com. Your communication should set out the details, explain what you think went wrong and what you feel would put things right. If you are not happy about writing it, you can always ask one of our staff members to take note of the complaint which you will be then asked to sign. You will be provided with a copy for your own reference. This record will be passed promptly to the Complaints Officer to deal with.

Once the Complaints Officer receives a written complaint, it shall be fully investigated. The complaint will be acknowledged in writing within five working days of receiving it and the letter will state when you can expect a full response. This should normally be within fifteen working days unless the matter is very complicated such as where other organisations need to be contacted. Where this is the case we will still let you know what action is being taken and will inform you when we expect to provide a full response.

TAKING YOUR COMPLAINT ELSEWHERE

If you are still not satisfied with the Complaints Officer's response, you can always seek advice elsewhere. You may contact:

Office of the Arbiter for Financial Services
N/S in Regional Road,
Msida MSD 1920,
Malta
Telephone: 8007 2366 or 21249245
E-mail: complaint.info@asf.mt
Website: www.financialarbiter.org.mt

The Office of the Arbiter will expect that you have a final reply to your complaint from us before approaching them.

DATA PROTECTION PERSONAL PROCESSING CLAUSE

The Proposer is hereby informed and expressly consents, by signing this document, to the processing of the data voluntarily provided in this document, as well as of any data which might be provided to MAPFRE Middlesea Plc or "The Company" directly or through an Insurance Intermediary, and those obtained by recording telephone conversations or as a result of browsing through Internet webpages or by other means, for the enforcement of the agreement or regarding a quotation, application, or the contracting of any service or product, even after the end of the pre-contractual or contractual relation, including, if applicable, any communication or international data transfer which might be made for the purposes specified in the Additional Data Protection Information which is available from any MAPFRE Middlesea Plc Office or through <https://bonniciinsurance.com/privacy-policy/>

The Proposer consents in turn to the recording of any telephone conversations with the Company regarding the insurance agreement.

MAPFRE Middlesea Plc may view the Proposer's data in files regarding the fulfilment and non-fulfilment of monetary obligations.

Should the data provided pertain to physical persons other than the Proposer, the latter guarantees that he/she has obtained and has their prior consent for the communication of their data and has informed them, prior to their inclusion in this document, of the purposes of the data processing, communications, and other terms established herein and in the Additional Data Protection Information.

The Proposer declares that he/she is older than eighteen (18) years of age. Likewise, should the data provided belong to minors, as the minor's parent(s) or guardian(s), he/she expressly authorises the processing of the said data, including; if applicable, data pertaining to health, for the management of the purposes specified in the Additional Data Protection Information which is available from any MAPFRE Middlesea Plc Office or through <https://bonniciinsurance.com/privacy-policy/>

The Proposer guarantees the accuracy and truthfulness of the personal data, including sensitive personal data provided, undertaking to keep them duly updated and to notify MAPFRE Middlesea Plc of any changes in them.

BASIC DATA PROTECTION INFORMATION

Controller:	MAPFRE Middlesea Plc
Purposes:	Management of the insurance agreement, creation of profiles for suitable enforcement of the insurance agreement, integral and centralised management of the relation with the MAPFRE Group, and delivery of information and advertising on MAPFRE Group products and services.
Standing:	Execution of the project.
Recipients:	Data may be communicated to third parties and/or data transfers may be made to third-party countries in the terms stipulated in the Additional Information.
Rights:	You can exercise your rights of access, rectification, removal, limitation, objection, and transferability, specified in the Additional Data Protection Information.

Additional Information:

You can view the Additional Data Protection Information which is available from any MAPFRE Middlesea Plc Office or through <https://bonniciinsurance.com/privacy-policy/>

Check this box if you object to the processing and communication of your personal data by MAPFRE Middlesea Plc for the delivery of information and advertising of the Company products and services, of the various MAPFRE Group companies, and of Third party companies with which any MAPFRE Group company has entered partnership agreements. If you do so, we will be unable to inform you of any discounts, gifts, promotions, and other benefits associated with the MAPFRE Group customer loyalty plans.

In any case, your consent to the treatment of your data for these purposes is revocable, and you may withdraw your consent or exercise any of the rights mentioned at any time as specified in the Additional Data Protection Information which is available from any MAPFRE Middlesea Plc Office or through <https://bonniciinsurance.com/privacy-policy/>

PROFESSIONAL SECRECY

I consent on my behalf and on behalf of any other person specified in this form (others), that the Company or any other member of the Group may exchange some or all of the information with my insurance intermediary, appointed experts, other insurance companies or the Malta Insurance Association for the purpose of administering my insurance proposal and policy, handling and settling of claims, detecting, preventing and suppressing fraud and the keeping of statistics. I also authorise (on my own behalf and on behalf of others) insurance companies and intermediaries to disclose information about or relevant to my insurance history for these purposes.

I understand (and have explained to Others) that when I tell the Company about an incident which may or may not give rise to a claim, the Company may pass information relating to it to the Malta Insurance Association and / or other insurance companies and intermediaries. In doing so we will ensure that this communication is carried out confidentially and within the terms of the Professional Secrecy Act, 1994

Material Facts are those facts which are likely to influence us in the acceptance or assessment of this proposal and it is essential that you disclose all of them. If you are in doubt about whether a fact is material then for your own protection you should disclose it since failure to do so could invalidate your policy.

DECLARATION

I have read or have had read to me the contents of the completed proposal form and agree that all the statements I have made and information I have provided are correct and complete in every respect and will form the basis of the contract between me and MAPFRE Middlesea p.l.c [us] . I undertake to notify MAPFRE Middlesea p.l.c of any change in the information subsequent to the submitting of this proposal form. I am satisfied with the way the proposal form has been completed and if it has been completed by an employee and / or authorised intermediary on my behalf such person, shall, for that purpose, be regarded as my / our agent. I understand that in the event of a finding of incomplete and/or non-disclosure of material information, MAPFRE Middlesea p.l.c reserves the right to repudiate the claim or declare the policy void. I understand and agree that by signing this Declaration I will be bound by the statements and disclosures of material facts herein contained. I acknowledge that a material fact is one which is likely to influence MAPFRE Middlesea p.l.c in the best assessment and acceptance of the proposal form. If in doubt as to whether a fact is material then it should be disclosed. I confirm that I have received, read and understood the 'Insurance Product Information Document', 'Information for Prospective Policyholders' and the quotation relevant to the product for which I am applying. I hereby agree that I have read the policy and am bound by the terms, conditions, limitations and exclusions of the said policy.

Before signing this document, please read the basic data protection information given in the PERSONAL DATA PROCESSING clause. By signing this document, you consent to the processing of your personal data, including sensitive personal data in the terms and conditions stipulated in said clause.

Period of insurance required	From:	To:
Signature of applicant	Date	
Intermediary		

COM: MMS070125
REF: BPIMAMF-V3.0-070125

Bonnici Insurance Agency Ltd (C-8614) is enrolled under the Insurance Distribution Act, Cap. 487 of the Laws of Malta, as an Insurance Agent for MAPFRE Middlesea p.l.c. (MMS). MMS (C-5553) is authorised by the Malta Financial Services Authority (MFSA) to carry on both long-term and general business under the Insurance Business Act, Cap. 403 of the Laws of Malta. Both entities are regulated by the MFSA.