GREAT AMERICAN INSURANCE COMPANY

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Medical Malpractice Liability Policy Proposal Form

Notice to the **Applicant** (given under section 25(5) of the Singapore Insurance Act, Cap 142): If you, the **Applicant**, do not fully and faithfully give the facts as you know them or ought to know them, you may receive nothing from the **Policy**.

Note to the Applicant:

1. This **Proposal** form is for the **Applicant** to complete and submit to **Great American** (together with all required information and documents) for the purpose of applying for medical malpractice liability insurance.
2. Please answer **ALL** questions fully. If there is insufficient space in this form for you to complete any of your answers, please attach a separate **signed** and **dated** sheet with your complete answer and identify the question number concerned.
3. In this **Proposal** form:
   a. "**Applicant**" means the entity or natural person intended to be the policyholder, defined as the **Policyholder** in the **Policy**.
   b. "**Great American**" means the Great American Insurance Company, Singapore Branch.
   c. "**Policy**" means **Great American Medical Malpractice Liability Policy**, a sample of which is available on request. For avoidance of doubt, references to the **Policy** shall not bind **Great American** to issue one.
   d. The words "**Employee**", "**Insured**", "**Limits of Liability**", "**Policy**", "**Policy Period**", "**Proposal**" and "**Subsidiary**" have the same meanings as defined in the **Policy**.

PLEASE READ THE ENTIRE POLICY AND THE PROPOSAL FORM CAREFULLY

1. General Information on Applicant

a. Applicant's name: _____

b. Applicant's principal address: _____

c. Applicant's branch office(s) or other locations:

_____

_____

d. Date on which the Applicant's practice was established: _____

2. Principals, Partners and Directors of the Applicant

a. Please provide details of each of the current Principals, Partners and Directors of the **Applicant**:

Name of each Principal, Partner, and Director	Qualification(s)	No. of years working in the same industry as the Applicant's*	No. of years as a Principal, Partner or Director of:	
			Applicant's Practice	Previous Practice(s)

*If a Principal, Partner or Director has worked in the relevant industry for less than three years, a brief resume of such Principal, Partner or Director with details of his/her career must be provided.

2. Principals, Partners and Directors of the Applicant *Continued*

b. Please complete details of your medical staff, clearly identifying those for which coverage under this insurance is sought.

Doctors	Employed		Non-Employed		Other Medical Staff	Employed		Non-Employed	
Coverage Required?	**Yes**	**No**	**Yes**	**No**	**Coverage Required?**	**Yes**	**No**	**Yes**	**No**
General Practitioners	☐	☐	☐	☐	Dentists	☐	☐	☐	☐
Psychiatrists	☐	☐	☐	☐	Registered Nurses	☐	☐	☐	☐
Radiologists	☐	☐	☐	☐	Nurse Practitioners	☐	☐	☐	☐
Obstertricians	☐	☐	☐	☐	Midwives	☐	☐	☐	☐
Gynaecologists	☐	☐	☐	☐	Nurse Anaesthetists	☐	☐	☐	☐
Anaesthetics	☐	☐	☐	☐	Lab Technicians	☐	☐	☐	☐
General Surgeons	☐	☐	☐	☐	Paramedics	☐	☐	☐	☐
Orthopaedic Surgeons	☐	☐	☐	☐	Complementary	☐	☐	☐	☐
Cosmetic Surgeons	☐	☐	☐	☐	Pharmacists	☐	☐	☐	☐
Trainee Doctors	☐	☐	☐	☐	Others	☐	☐	☐	☐
Opthalmology	☐	☐	☐	☐	(Please specify) _____				

Please complete the above table using Full Time Equivalents (FTE). An FTE is equivalent to a 40-hour week, on an annual basis.

		Yes	No
c.	Have the numbers of medical staff changed significantly over the past five years? **If yes**, please provide details by completing Addendum 3	☐	☐
d.	Do you require that all professionally qualified medical staff:		
	i. Are registered with or licensed by the relevant government regulatory body or licensing and registration body?	☐	☐
	ii. Are adequately trained and competent for their role?	☐	☐
	iii. Are adequately supervised under the appropriate management?	☐	☐
	iv. Are re-credentialed on at least an annual basis? **If no**, how often are medical staff members re-credentialed?_____ _____	☐	☐
e.	Do you require that all non-employed medical staff:		
	i. Carry their own medical professional liability insurance or maintain Indemnity via a Medical Defence Organisation? **If yes**, please specify the limits required: _____ _____	☐	☐
	ii. Provide evidence of this coverage on an annual basis?	☐	☐

3. Subsidiaries

		Yes	No
a.	Does the **Applicant** have any **Subsidiary**?	☐	☐

b. If the answer to Question 3(a) is **yes**, please give the following details of each **Subsidiary** of the **Applicant**.

Name of Subsidiary	Address of Subsidiary	Subsidiary's date and place of incorporation	Description of Subsidiary's business(es) and activities	Length of time Subsidiary has continuously carried on business

4. Details of Applicant's Practice

		Yes	No
a.	Please answer the following questions:		
	i. Has the name of the **Applicant** ever been changed?	☐	☐
	ii. Has the **Applicant** acquired, merged or amalgamated with any other practice(s) or business(es); or been acquired or merged by or amalgamated with any other practice(s) or business(es)?	☐	☐
	iii. Has the name of the **Applicant** ever been changed?	☐	☐
	iv. Is any Partner, Principal or Director of the **Applicant** connected or associated (financially or otherwise) with any other practice or business?	☐	☐

If the answer to any of the above is yes, please provide full details including confirmation of the position relating to past liabilities assumed by either practice(s) and/or business(es).

b. Please provide details of any substantial changes in activities or operations of the **Applicant** or major new activities or operations of the **Applicant** undertaken during the last 12 months or planned for the next 12 months.

_____

_____

c. Please list the professional bodies or associations to which the **Applicant** or any **Subsidiary** belongs.

_____

_____

d. Please detail the approximate percentage of the **Applicant's** income/fees derived from the following fields of work:

	Type of Work			Type of Work	
i.	Acupuncture	_____%	ii.	Chiropractic	_____%
iii.	Audiology/Audiometrics	_____%	iv.	Massage	_____%
v.	Optometry	_____%	vi.	Nutrition/Dietetics	_____%
vii.	Beauty Therapy/Aesthetics	_____%	viii.	Pathology	_____%
ix.	Hair and Scalp Treatment	_____%	x.	Clinic Research	_____%
xi.	Chiropody	_____%	xii.	Physiotherapy	_____%
xiii.	Podiatry	_____%	xiv.	Psychology	_____%
xv.	Chemical/Pharmaceutical	_____%	xvi.	Speech Therapy	_____%
xvii.	Dentistry/Orthodontics	_____%	xviii.	Occupational Therapy	_____%
xix.	Home Nursing	_____%	xx.	Naturopathy	_____%
xxi.	Osteopathy	_____%	xxii.	Others (Answer Qn 4(e))	_____%
				Total:	_____%

e. If Question 4(d)(xxii) above applies, please provide details of the precise nature of the **Applicant's** other activities or business.

_____

_____

f. Please categorise the **Applicant's** other activities or business in the answers to Question 4(e) and provide the approximate percentage of income/fees derived for each such activity/business:

Business/Activities	Percentage (%) of Income/Fees
Total:	

g. Please provide details of advice given in relation to the activities or business in Question 4(d) or 4(e).

_____

_____

4. Details of Applicant's Practice *Continued*

		Yes	No
h.	Are verbal reports always confirmed in writing? **If the answer is no**, please state how the **Applicant** substantiates verbal reports? _____ _____	☐	☐
i.	Does any one contract or client represent more than 50% of the **Applicant's** annual work or fees?	☐	☐
j.	Does the **Applicant** engage any consultants, agents or sub-contractors?	☐	☐
k.	If the answer to Question 4(j) is **yes**, does the **Applicant** enter into any hold-harmless agreement(s) or otherwise waive any legal rights or entitlements which the **Applicant** may have against such consultants, agents or sub-contractors?	☐	☐
l.	If the answer to Question 4(j) is **yes**, does the **Applicant** always insist and confirm that the consultants, agents and/or sub-contractors carry their own professional indemnity insurance?	☐	☐
m.	Does the **Applicant** conduct any activities outside Singapore or provide services for clients outside Singapore? **If the answer is yes**, please provide details. _____ _____ _____	☐	☐
n.	Does the **Applicant** conduct any activities in the USA and/or Canada or work for clients located in the USA and/or Canada? **If the answer is yes**, please provide details. _____ _____ _____	☐	☐
o.	Does the **Applicant** have any **Subsidiary** located in the USA and/or Canada? **If the answer is yes**, please provide details including the total assets and total revenue from the Applicant's USA and/or Canada subsidiaries and activities. _____ _____ _____	☐	☐

5. Applicant's Financial Details

a. Date of **Applicant's** financial year end: _____

b. Please provide the amount of the largest annual fee for any one client. _____

c. Please provide the following details on the **Applicant's** total amount of gross income / fees. _____

	Year	Singapore	USA/Canada	Elsewhere (Please provide details)
i.	**Previous complete financial year**			
ii.	**Current financial year**			
iii.	**Estimate for next financial year**			

d. Please provide the approximate percentage of the **Applicant's** activities (based on fee income) applicable to each state and territory where the Applicant conducts activities or provides services.

Country	Singapore	Asia	Europe	USA/Canada	Others
Percentage of Income	_____ %	_____ %	_____ %	_____ %	_____ %

6. Other Insurance

		Yes	No
a.	Has the **Applicant**, any **Subsidiary** or any Partner, Principal or Director of the **Applicant** ever been:		
i.	Refused coverage under any medical malpractice liability insurance or had any similar policy cancelled?	☐	☐
ii.	Declined an application to renew any medical malpractice liability insurance?	☐	☐
iii.	Required to have special terms imposed on the **Applicant's**, any **Subsidiary's** or any of the Applicant's Partner's, Principal's or Director's current or prior medical malpractice liability insurance?	☐	☐

If the answer to any of the above is **yes**, please provide full details:

iv.	Does the **Applicant**, any **Subsidiary** or any Partner, Principal or Director of the **Applicant** currently have or ever had medical malpractice liability insurance?	☐	☐	

If the answer to any of the above is **yes**, please provide full details:

Name of Insurer	Name of Policyholder and whether Applicant, Subsidiary or Applicant's Partner/Principal/Director is insured	Policy Period	Limit of Liability/Indemnity (S$)	Deductible (S$)

7. Prior Knowledge / Warranty

		Yes	No
a.	Has any Partner, Principal, Director or staff member of the Applicant ever been subject to disciplinary proceedings for professional misconduct?	☐	☐
b.	Have any claims for negligence or breach of professional duty been made in the last 10 years against:		
i.	The **Applicant** or any entity which the **Applicant** previously practiced as under a different name?	☐	☐
ii.	Any **Subsidiary**?	☐	☐
iii.	Any current or former Principal, Partner or Director of the **Applicant**?	☐	☐
iv.	Any current or former Employee?	☐	☐
v.	Any potential Insured other than those mentioned in sub-paragraphs (i) to (iv) above?	☐	☐
vi.	Any agent or consultant of the Applicant, any Subsidiary or any other potential Insured?	☐	☐
vii.	Any member of a board of management or committee of the Applicant or any Subsidiary?	☐	☐

If the answer to any part of Question 7(b) is **yes**, please provide the following details:

Date of Notification	Name of Insurer (if any)	Name of Claimant or Potential Claimant	Brief Description	Amount Paid or Estimated Potential Liability	Is matter finalised or outstanding?

7. Prior Knowledge / Warranty *Continued*

c. Is the **Applicant**, any **Subsidiary** or any Principal, Partner, Director or Employee of the Applicant after inquiry aware of any facts or circumstances which:

		Yes	No
i.	It, he or she has reason to believe may give rise to claim(s) that fall within the scope of the proposed coverage in the **Policy** or may give rise to claim(s) by any potential Insured under the **Policy**?	☐	☐
ii.	Indicate the probability of any such claim(s)?	☐	☐

If the answer to Question 7(c)(i) or 7(c)(ii) is **yes**, please provide the following details in respect of each matter:

Name of Claimant or Potential Claimant	Brief Description of Matter	Estimate of Potential Liability

*If the answer to any of the above is **yes**, full details of each matter must be provided before quotation can be considered. You are reminded that it is imperative that these questions must be answered correctly. **Failure To Do So Could Prejudice the Rights** of potential Insured, if a claim should subsequently arise. Please attach details on separate sheets if necessary.*

8. Limits of Liability

What **Limits of Liability** are quotations required for?

☐ $1,000,000.00 ☐ $2,000,000.00 ☐ $5,000,000.00 ☐ $10,000,000.00

☐ Others (Please specify) _____

9. False Information

Please note that any person who, knowingly and with intent to defraud any insurance company or other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime

10. Personal Data Collection Statement

1. In order to process, evaluate, administer and/or manage your application, relationship, account and/or policy with Great American Insurance Company, Singapore Branch ("**Great American**"), Great American will necessarily need to collect, use, disclose and/or process your personal data or personal information about you. Such personal data includes (i) information set out in this statement and any other personal information provided by you or already in the possession of Great American as previously provided by you; and (ii) your claims.
2. Such personal data will be collected, used, disclosed and/or processed by "Great American for the purpose(s) of:
   a. considering whether to provide you with the insurance you applied for including considering whether to accept any renewal request;
   b. processing your application for underwriting and insurance;
   c. administering and/or managing your relationship, account and/or policy with Great American;
   d. processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under your policy;
   e. carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by Great American;
   f. carrying out your instructions or responding to any enquiries by you;

10. Personal Data Collection Statement *Continued*

g. dealing in any matters relating to the services and/or products which you are entitled to under a policy which you are applying for or have applied for (including the mailings of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of certain personal data about you to bring about delivery of the same as well as on the external cover of envelopes/mail packages);

h. investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your renewal request, your claims or any other matter relating to your policy, and whether or not there is any suspicion of the aforementioned; and/or

i. complying with applicable law in administering and managing your relationship with Great American.

(collectively the "**Purposes**")

3. We may/will also be collecting from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.

4. Your personal data may/will be disclosed by Great American to affiliates of Great American and third parties such as third party service providers, reinsurers or agents (including its lawyers / law firms) ("**Relevant Parties**"), which may be sited outside of Singapore, for one or more of the above Purposes, and such Relevant Parties would be processing your personal data for Great American in relation to one or more of the above Purposes.

   c. consent to Great American disclosing your personal data to the Relevant Parties, for the Purposes as described above; and

   d. consent to Great American transferring your personal data out of Singapore to the Relevant Parties, for the Purposes as described above.

5. By signing below, you:

   a. consent to Great American collecting, using, disclosing and/or processing your personal data for the Purposes as described above;

   b. consent to Great American collecting personal data about you from sources other than yourself and using, disclosing and/or processing the same, for one or more of the Purposes as described above;

   c. consent to Great American disclosing your personal data to the Relevant Parties, for the Purposes as described above; and

   d. consent to Great American transferring your personal data out of Singapore to the Relevant Parties, for the Purposes as described above.

☐ I have read and agree to the above.

Name _____ **NRIC No.** _____

(signature) _____ **Date** _____