Professional Indemnity For Doctors

(For cover to be considered this declaration must be completed in full and all questions answered)

1. Name Of Proposer Dr. ______________________________

   Last Name   Other Names

2. Address Of The Practice

	Box Number	Postal Code	Town
Principal Office			
Subsidiary Office			

3. Area of specialization of the proposer ______________________________
4. Pin Number (provide copy): ______________ Email Address: ______________
5. Telephone: ______________ Mobile No. ______________
6. Have any claims been made against you or your Employees for the type of cover for which you are now applying?

   Yes ☐ No ☐

   If YES; please give details: ______________________________

7. Are you aware of any circumstances which would be covered under a policy of this type that may result in any claims or a possible claim being made against you?

   Yes ☐ No ☐

   If YES; please give full details (attach page at the back if necessary)

8. Are you at present or in the past been insured for this type of insurance? Yes ☐ No ☐

   If yes, state the name of insurance company ______________________________

   Limit of indemnity ______________________________

   Expiry date ______________________________

   Whether the policy includes a run off cover and if so what period

9. Has any insurance company

   (a) Declined your proposal? Yes ☐ No ☐

   (b) Cancelled or failed to renew your policy? Yes ☐ No ☐

   c) Increased premium on renewal? Yes ☐ No ☐

   If yes to any of the above, please give details

AAR INSURANCE KENYA LIMITED
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• **F** 020 - 2715328 •**E** Info@aar.co.ke • **W** www.aar-insurance.com

10. a) At which Medical School did you obtain your Qualifications?

____

b)What degree did you obtain and in which year? ______________________________

____

11. Have you practiced your profession since graduation and for how many year(s)?

Practiced Proffession	Year(s)
1.	
2.	
3.	
4.	

12. Are you duly licensed in accordance to the law to practice at the address specified in the above?

____

13. Of what Proffessional Association are you a member in good standing? ______________________________

____

14. List names of all qualified assistants who are currently working for you.

Name	Career Type	Qualifications
1.		
2.		
3.		
4.		

15. Are you in good standing with your professional association? Please provide details ______________________________

____

16. Have you suffered any physical, physiological, emotional, pathologic or psychiatric disability? ☐ Yes ☐ No

If YES; please give details ______________________________

____

17. State the average number of patients you attend to per day. ______________________________

Agent / Broker's Declaration

I / We hereby declare that I/We have explained to the client the terms, exclusions and conditions of this cover

Signature: ______________________ Name: ______________________ Mobile No. ______________________

PROPOSER DECLARATION

I / We hereby declare and warrant that the statements given above are true and complete and agree that this proposal and declaration shall be the basis of the proposed contract between the company and myself/ou selves. I/We further agreed to accept a policy on the usual company terms and conditions for this class of insurance.