EXPERTS DOCTORS SHIELD SERVICES LTD.

By the experts - for the Doctors

(Widely known as DOCSHIELD)

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MEMBERSHIP REGN. FORM FOR MEDICAL ESTAB.

In business arrangement with a leading insurance company of India

Membership Date

Date **Month** **Year**

Branch : ....

Code : ....

I/we the owner (s) Director (s) Prop. of M/s..

hereby Voluntarly agree to be a member of Experts Doctors Shield Services Ltd. and I/we are am depositing Rs................for ....years as per details given below towards the expenses to be incurred on Errors & Omission Insurance coverage, as well as legal & administrative charges of the company, asprovided under the policy and scheme of Experts Doctors Shield Services Ltd.

Amount	D/D or A/C payee / Cheuqe No.	Date	Bank	Drawn

Particulars :

Name of Medical Estab.

Owner / Director / Prop

Address: Hospital/Nursing Home/Diag.Centre:

State the number of employees (including visiting doctors)

General Physicians ____________ Trainees ____________

Plastic Surgeons ____________ Voluntary Workers ____________

Dentists ____________ Other (Please Specify) ____________

Pharmacists ____________ Specialists including Surgeon in different disciplines ____________

Technicians ____________ a) EYE/ENT ________ b) Pathologists ________ c) Anaesth ________

d) Radiologists ________ e) Cardiologists ________ f) Gynaecologist ________

Do you have Ambulance, if yes specify number____________________________________

Number of OPD ____________ Number of IPD____________ Number of Beds ____________

Telephone No. Clinic Residence :

Mobile : E-mail: ____________________

Registration No. Year :

Other Particulars (If any) ....

I/we hereby declare that I/we have fully understood the policy/scheme and shall abide by the rules and regulations of Experts Doctors Shield Services Ltd. In case of non-payment in full in time, the Expert Doctors Shield Services Ltd. Will have the right to forfeit the amount deposited by me/us.

Signature of Owner / Prop. / Director of Med. Estab.

Signature of Executive / Promoter

UNITED INDIA INSURANCE COMPANY LTD.

(A Govt. of India Undertaking)

Regd. & Head Office : United India House, 24 Whites Road, Chennai-600014

PROPOSAL FORM FOR MEDICAL ESTABLISHMENT ERRORS & OMMISSIONS INSURANCE

This proposal must be signed. All question must be answered. The completion and signatu e of this proposal does not bind the proposer or insure to complete a contract of insurance.

If the space is insufficient to answer questions, please use additional sheets and attach it to this form. The company does not assume any liabilities until the proposal has been accepted and premium paid

1) Name of the proposer .
   Address

2) Year in which established :

3) Names & Addresses of owners/directors/partners

4) Have you complied with all statutory rules/

5) Are the Doctors/Nurses/Technicians Working for you
   a) Duly licenced in accordance with the Medical acts or any other prevelant laws

   b) Members of Medical Association/Council

6) State the number of employee (including visiting doctors) in act of the following classifications)

   1. General Physicians
   2. Specialists including Surgeons in different diciplines.
      a) EYE/ENT
      b) Pathologists
      c) Cardiologists
      d) Radiologists
      e) Orthopaedics
      f) Gynaecologist
      g) Psychiatrist
      h) Neurologist
      i) Paediatrician
      j) Urologists
      l) Dermatologist
      m) Oncologist
      n) Anaes Thetists
   3. Plastic Surgeons
   4 Dentists
   5. Pharmacists
   6. Technicians
   7. Nurses
   8. Trainees
   9. Voluntary Workers
   10. Other (Please specify)

7) (a) Please Specify all the facilities. available like X-ray, Scanning, pathology etc.

   (b) Whether persons operating these are qualified and well experiences.

8) Do you have Ambulance. If Yes, specify number

9) Do you have out patients departments Please specify estimated No. of patients to be treated in a year.

10) State . No of beds maintained
    No. of Dassinetted for maternity cases

11) Estimated No. of in-patients (actuals)
    Previous year . estimated current year)
    to be treated in a year

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	PREVIOUS YEAR (Annual)	CURRENT YEAR (Estimated)
a. General		
b. Medical		
c. Surgical		
d. Any other class (please specify)		

12) Give details of radioactive treatment facility. Specify the material used and precautions taken further for such usage.

13) Do you undertake training of staff?
A) If yes, Please give details
b) Nature of supervision over such trainees.

14) Whether food is supplied by you to patients if yes, specify whether it is prepared by you or supplied by outsiders. If supplied by you. Please specify the measures taken for maintainance of kitchen and other supervisory measures..

15) Do you supply medicines to patients ?

16) State/estimated annual income (this includes Room charges, Operation theatre. Rent, Charges for X-ray facilities, Doctors fees, Nursing charges, Medicines, Food Surcharges and any other income)

17) Details of the claim lodged against the proposer during the past 5 years on account of services rendered by your establishment.

18) Have you ever insured against liabilities in the past? If so, specify the name of the insurer, policy number and period.

19) Has any insurer cancelled/declined/refused to renew your liability insurance or accepted your proposal subject to restrictions.

20) Details of any event likely to give rise to a liability claim against you at a future date.

21) State limits of indemnity required for any one year.

22) Period of Insurance required From....................................to..

23) Valuntary Excess

I/We hereby declare that the above statement and particulars are true and I/We have not surpressed of misstated any material facts and that at the present time I/We have not reason to anticipate any claim being brought against me/our or any negliged act, error or ommission on my/our and against the Company and agree that this deciaration shall be the basis of the contract between me/us and the Insurer. I/We also that the indemnity occur the insurance shall not be availed for claims, arising out of acts of negligence, error or ommission or misconduct committed PRIOR to commencement of this insurance.

Date :
Place :

SIGNATURE OF PROPOSER

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