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Category Opted

PROPOSAL FORM FOR DOCTORS AND MEDICAL PRACTITIONERS GYNAECS & OBSTETRICIANS

INDIVIDUAL DOCTORS

1. Name of the Doctor Member :
2. Address for Correspondence :
3. Email ID :
4. All Contact Numbers :
5. Name of the Affiliated Society :
6. Professional Qualification and the year of such Qualification :
7. Medical Registration Number :
8. Are you a member of any Medical Association / Council, if so, please state Name and Address of such Association / Council with Membership Number :
9. Are you resident doctor without any Private Practice or Consultancy ? :
10. Has any claim been made upon you or Legal Proceedings institute or likely to be instituted against you by patients in respect of your treatment etc. If so, please give details :
11. Have you been previously insured for the subject risk ? If so, please give full details :
12. Limit of Indemnity (liability) required (Please tick the option)
    Any One year :
    (Multiple incidents aggregating to Rs.60 Lacs, Rs.40 Lacs and Rs.20 Lacs respectively as per option chosen)
    OR
    Any One Incident :

Rs.60 Lacs	Rs.40 Lacs	Rs.20 Lacs

I here declare that the above statement and particulars are true to the best of my knowledge and I have not suppressed or misrepresented any material facts and that at present time. I have no reason to anticipate any claim being brought against me for any negligent act, error or omission on my part and agree that this declaration shall be the basis of contract between me and the Insurer.
I also agree that the Indemnity under the insurance shall not be availed for claim arising out of acts of negligence error or omission or misconduct committed prior to commencement of this insurance.

Date :

Place : **Signature of the Proposer**

UNDERTAKING :
I hereby undertake to repay entire amount to UIIC (through FOGSI) which was paid by United India Insurance Co.Ltd., towards Defense Coasts, etc. if there is a conviction against me on criminal charges.

Signature of the Proposer

Secretary General
Authorised Signatory of FOGSI

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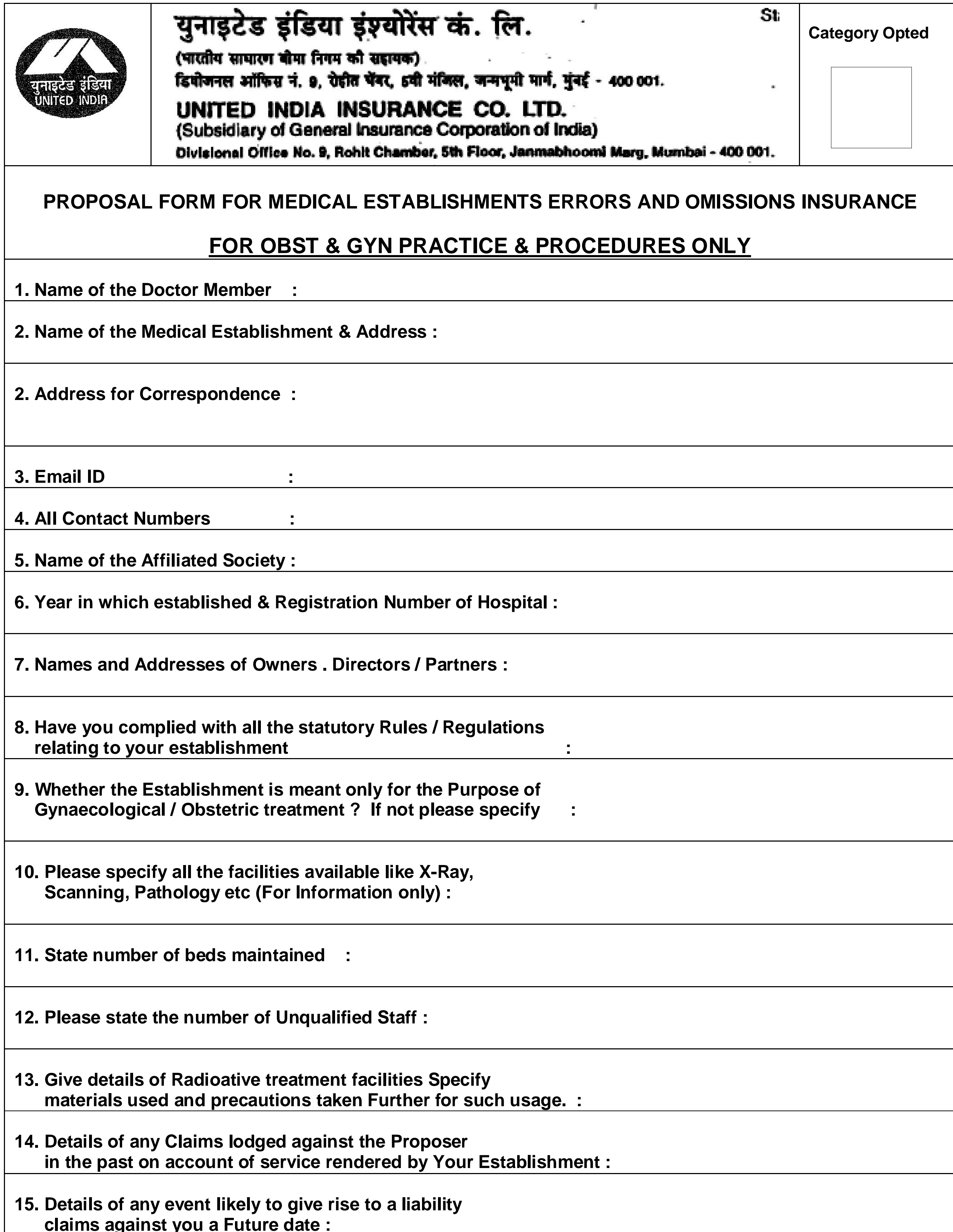

युनाइटेड इंडिया
UNITED INDIA

युनाइटेड इंडिया इंश्योरेंस कं. लि.
(भारतीय साधारण बीमा निगम की सहायक)
डिवीजनल ऑफिस नं. ९, रोहीत चेंबर, ५वी मंजिल, जन्मभूमी मार्ग, मुंबई - 400 001.

UNITED INDIA INSURANCE CO. LTD.
(Subsidiary of General Insurance Corporation of India)
Divisional Office No. 9, Rohit Chamber, 5th Floor, Janmabhoomi Marg, Mumbai - 400 001.

Category Opted

PROPOSAL FORM FOR MEDICAL ESTABLISHMENTS ERRORS AND OMISSIONS INSURANCE

FOR OBST & GYN PRACTICE & PROCEDURES ONLY

1. Name of the Doctor Member :

2. Name of the Medical Establishment & Address :

2. Address for Correspondence :

3. Email ID :

4. All Contact Numbers :

5. Name of the Affiliated Society :

6. Year in which established & Registration Number of Hospital :

7. Names and Addresses of Owners . Directors / Partners :

8. Have you complied with all the statutory Rules / Regulations relating to your establishment :

9. Whether the Establishment is meant only for the Purpose of Gynaecological / Obstetric treatment ? If not please specify :

10. Please specify all the facilities available like X-Ray, Scanning, Pathology etc (For Information only) :

11. State number of beds maintained :

12. Please state the number of Unqualified Staff :

13. Give details of Radioative treatment facilities Specify materials used and precautions taken Further for such usage. :

14. Details of any Claims lodged against the Proposer in the past on account of service rendered by Your Establishment :

15. Details of any event likely to give rise to a liability claims against you a Future date :

P.T.O.

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16. State Limit of Indemnity (liability) required (Please tick the option) Any One year : (Multiple incidents aggregating to Rs.60 Lacs, Rs.40 Lacs and Rs.20 Lacs respectively as per option chosen) OR Any One Incident :	**Rs.60 Lacs**	**Rs.40 Lacs**	**Rs.20 Lacs**

I here declare that the above statement and particulars are true to the best of my knowledge and I have not suppressed or misrepresented any material facts and that at present time. I have no reason to anticipate any claim being brought against me for any negligent act, error or omission on my part and against the company and agree that this declaration shall be the basis of contract between me and the Insurance company.
I also agree that the Indemnity under the insurance shall not be availed for claims arising out of acts of negligence, error or omission or misconduct committed prior to commencement of this insurance.
OR for claims other than Obst & Gyn practice & procedures.

Date :

Place : **Signature of the Proposer**

UNDERTAKING :
I hereby undertake to repay entire amount to UIIC (through FOGSI) which was paid by United India Insurance Co.Ltd., towards Defense Costs, etc. if in case there is a conviction against me on criminal charges.

Signature of the Proposer

Secretary General
Authorised Signatory of FOGSI

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Consent Form

There in no prior on pending litigation and you have no knowledge of any situation which may give rise to a claim.