GOLDEN NOURAN
INSURANCE BROKERAGE
شركة نوران الذهبية لوساطة التأمين

Medical Malpractice Insurance تأمين الأخطاء الطبية

Please arrange below documents to request the rates:

1. Fill the complete attached proposal form and sign
2. ID copy
3. ID copy of the Health council.
4. National Address
5. Fill the Limit of Indemnity Required
6. Period of Insurance - 01 Year or 02 Years or 03 Years

Medical Malpractice Insurance Proposal Form

Name of the Proposer: Full Business and Partnership Name (if any)
Address:
Tel: Cell: Fax: Email:
Date of Birth / / Nationality: Occupation:
Location of Practice:
Period of Insurance: From: To:
Limit of Indemnity Required Any One Occurrence SR……..And in the Annual Aggregate SR…….
At what medical school(s) did you qualify? In what year(s)? With what degree(s)?
Where have you practiced your profession since graduation? In…….during the years In…….during the years In…….during the years In during the years
What branches of Medical profession are you qualified and licensed to practices a) General Practice, Dentistry, Anesthesiology, Surgery, Nursing, Lab Technician, etc. b) Surgical or non Surgical Provide details:……... ……..
Are you Licensed in Saudi Arabia for the branch or branches of medical your are practicing ☐ Yes ☐ No
Of what professional association or societies are you a member of good standing?
Are you Board Certified, if yes a) in what specialty b) when
Please state your annual Gross Fee income
a) Name of Partners (each partner must complete a Proposal Form)……... b) If you are not the employee of a practice, name all qualified assistant, Technicians, Nurse Anesthetists, other Nurses And their qualification
Please advise whether you have had medical professional liability insurance during the past 12 months ☐ Yes ☐ No If yes please give the name of the insurer
Has any company declined or cancel to offer to you professional liability insurance ☐ Yes ☐ No If yes please give details
Have any claims or suit of negligence, error or omission been made against you? ☐ Yes ☐ No Are you aware of any claims or suits for negligence, error, omission that may have been made against any of your partners, assistants, nurses or technicians? ☐ Yes ☐ No Are you aware of any circumstances which may result in any such claims or suit being made? ☐ Yes ☐ No If your answer to any of the above is Yes, please provide full details
DECLARATION: I hereby declare that the answers given in the proposal are true to the best of my knowledge and I have not withheld or suppressed any material fact. A material fact is one which is likely to influence the Insurers acceptance or assessment of this proposal. If there is any doubt whether facts are material or not they should be disclosed as failure to do so may result in the insurance being declared void. I agree also to notify the Insurer of any material change.
Proposer's Signature: Date: