



Mediserve Professional Indemnity

(Please answer all questions in BLOCK letters)

NOTE:

1. Please answer all the questions fully and correctly. If a particular question is not applicable to You please mark that question as not applicable "N/A".
2. Please leave one box blank between two words while writing address.

Our liability does not commence until the acceptance of the proposal has been formally intimated to the Insured Person and full premium has been realized by Us.

Policy Issuing Office Address & Code	
Intermediary/Agent Name (if any)	
Intermediary/Agent Code (if any)	
Intermediary/Agent Contact Number/ Email ID	Phone No.: Email ID:

The liability of the Company does not commence until this proposal has been accepted by the Company and premium paid.

Information given herein will be treated in strict confidence.

GENERAL INFORMATION / DETAILS OF THE PROPOSER

1. Name of Proposer

2. Present Address of Proposer

 City District
 State Pin Code

Is your present address same as your permanent address? Yes No

If no, please state your permanent address along with pin code:

City District
 State Pin Code

Address proof (document & number)

3. Phone No. a. Mobile b. Landline

4. Email

5. Identity proof (document & number)

6. Income proof

7. PAN (document & number)

8. Existing KYC Number, if any

9. Policy to be issued in favor of (list out all the parties who have insurable interest) including the financial institutions

10. Do you require insurance for more than 1 year Yes No

11. Period of Insurance required From: To:

12. Limit of Liability required

Any one Incident: _____

Any one-year Limit: _____

Telehealth Services Limit: _____

PROFESSIONAL INFORMATION OF THE PROPOSER

13.	Proposer Type	<input type="checkbox"/> Partnership firm <input type="checkbox"/> Private Company <input type="checkbox"/> Public Company
14.	Date of Establishment	
15.	Please list all the Specializations of the Healthcare and Telehealthcare Services provided by the Proposer	
16.	Please answer with "Yes" or "No" a) Are you a standalone Diagnostic service provider? _____ b) If response to above query is "Yes", Accreditation received from: i. National Accreditation Board for Medical Imaging Services (NABMIS) _____ ii. National Accreditation Board for Laboratories (NABL) _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
17.	Full details of work carried on (Please attach brochure, information booklet, etc. if any)	
18.	Registration Number provided by local competent authority	
19.	Have you complied with all statutory rules/regulations relating to your establishment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
20.	Are the Doctors / Nurses / Technicians working for you Duly licensed in accordance with the Medical Acts or any other prevalent laws	Yes <input type="checkbox"/> No <input type="checkbox"/>
21.	Specify No. of employees, their job specifications, (Note: Only Qualified Assistants, Nurses or any qualified technicians under your contract of employment)	

22.	State the number of employees (including visiting doctors) in each of the following classifications; <ol style="list-style-type: none"> 1. General Physicians 2. Plastic Surgeons 3. Dentists 4. Pharmacists 5. Technicians 6. Nurses 7. Trainees 8. Voluntary Workers 9. Other (Please specify) 10. Specialists including Surgeons in different disciplines. <ol style="list-style-type: none"> a) Eye / ENT b) Pathologists c) Cardiologists d) Radiologists 	Please provide a separate list																		
23.	Please specify all the facilities available like X-ray, scanning, pathology, etc.																			
24.	Is the establishment under care of a qualified doctor round the clock at the premises?	Yes <input type="checkbox"/> No <input type="checkbox"/>																		
25.	Is a qualified nurse in attendance round the clock at the premises?	Yes <input type="checkbox"/> No <input type="checkbox"/>																		
26.	Please state the no. of Beds including bassinets maintained																			
27.	State no of fully equipped operation theatres																			
28.	No. of patients treated	<table border="1"> <tr> <td colspan="3" data-bbox="804 1460 1107 1496">Outpatient Department</td> </tr> <tr> <td data-bbox="804 1509 1037 1599">Previous Year</td> <td data-bbox="1037 1509 1270 1599">Current Year YTD __/__/</td> <td data-bbox="1270 1509 1503 1599">Estimated Next Year</td> </tr> <tr> <td data-bbox="804 1599 1037 1657"></td> <td data-bbox="1037 1599 1270 1657"></td> <td data-bbox="1270 1599 1503 1657"></td> </tr> <tr> <td colspan="3" data-bbox="804 1688 1082 1724">Inpatient Department</td> </tr> <tr> <td data-bbox="804 1738 1037 1827">Previous Year</td> <td data-bbox="1037 1738 1270 1827">Current Year YTD __/__/</td> <td data-bbox="1270 1738 1503 1827">Estimated Next Year</td> </tr> <tr> <td data-bbox="804 1827 1037 1886"></td> <td data-bbox="1037 1827 1270 1886"></td> <td data-bbox="1270 1827 1503 1886"></td> </tr> </table>	Outpatient Department			Previous Year	Current Year YTD __/__/	Estimated Next Year				Inpatient Department			Previous Year	Current Year YTD __/__/	Estimated Next Year			
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Previous Year	Current Year YTD __/__/	Estimated Next Year																		

29.	Please fill adjoining table in relation to in – patient department patient count	Particulars	Previous Year	Current Year YTD _/_/	Estimated Next Year
		General			
		Medical			
		Surgical			
	<u>For Diagnostic Centers only:</u> No. of customer diagnosed	Previous Year	Current Year YTD _/_/	Estimated Next Year	
30.	Please Give details of radioactive treatment facility. Specify the materials under and precautions taken for such usage				
31.	Please state annual income/revenue of last completed financial year				
32.	Please state annual income/revenue of last completed financial year				
33.	Have you ever insured against liabilities in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If “Yes”, give full particulars in Table - in this document	
34.	Are you aware of any neglect, omission or error or existence of any circumstances likely to give rise to a claim?				
35.	Has any company/Insurer in respect of Declined your Proposal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	Cancelled or refused to renew your policy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	Accepted your proposal on special terms and conditions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
36.	Please refer to Annexure 1a for queries if extensions are required				

CO-INSURANCE

Company Name	Percentage %	Premium (₹)

OTHER INFORMATION

Any additional information relevant to the Policy

TABLE - 1: NOMINATION DETAILS

Nominee Name	Nominee Relation	Nominee DOB	Age	Nomination %	Appointee Name if in case of Minor Nominee	Appointee Relationship, if Nominee is minor

TABLE - 2: EXISTING/ PREVIOUS INSURANCE POLICY DETAILS

Please provide details of your existing Insurance policies (if any):

Policy No. / Application No.	Insurer Name	Period of Insurance		Sum Insured	Claims lodged during the preceding years
		From	To		
		DDMMYYYY	DDMMYYYY		
		DDMMYYYY	DDMMYYYY		
		DDMMYYYY	DDMMYYYY		

Note: Please use additional sheets if space is not sufficient to complete details

DECLARATION BY INSURANCE COMPANY**ANTI- FRAUD WARNING:**

This policy shall be voidable at the option of the HDFC ERGO in the event of mis-representation, mis-description or non-disclosure of any material particulars by the Applicant. Any person who, knowingly and with intent to defraud the insurance company or any 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 will render the policy voidable at the sole discretion of the insurance company and result in a denial of insurance benefits.

DATA PROTECTION REQUIREMENT:

"I/We hereby understand, declare, consent and authorize the Company that all details of the policy and financial information, as provided to the Company may be utilized for processing the claim made under the Policy. I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance."

ANTI- MONEY LAUNDERING:

The Company believes in adherence to Anti Money Laundering (AML) guidelines/rules as it aids in ensuring that financial institution like ours are not used as vehicle for money laundering. The policyholder/ nominee are thus bound to provide such information as may be required by the Company for ensuring the adherence of AML guidelines/rules.

SHARING OF INFORMATION CLAUSE:

The information sought from the insured is strictly for the purpose of policy issuance and policy servicing. This information sought and the details of policy are kept confidential and will not be shared with any external party in any circumstances whatsoever. However, in instances when such information/ details is sought by any governmental bodies / regulatory authorities or when the Company is directed to share such information in accordance with any law/ regulations or direction from any such governmental bodies / regulatory authorities, the Company will be bound to abide to such directions.

A. PREMIUM DETAILS

PREMIUM DETAILS:	
Amount (INR) _____	GST (INR) _____
Premium including tax (INR) _____	Rupees in words _____
PAYMENT DETAILS:	
Cheque NEFT _____	
Instrument No. _____	Instrument Date: _____
Bank Account No. _____	
Account Type: Savings <input type="checkbox"/> Current <input type="checkbox"/> Other <input type="checkbox"/> If others, please specify _____	
Branch Name & Address: _____	
IFSC Code _____ MICR Code _____	
Bank details for refund of premium in case of cancellation to be considered as above - Yes <input type="checkbox"/> No <input type="checkbox"/>	
If NO, please provide additional bank details in below provided space:	
Bank Account No. _____	
Account Type: Savings <input type="checkbox"/> Current <input type="checkbox"/> Other <input type="checkbox"/> If others, please specify _____	
Branch Name & Address: _____	
IFSC Code _____ MICR Code _____	
Nationality: Indian <input type="checkbox"/> Non – Indian <input type="checkbox"/>	
If Non-Indian, please specify Country: _____	
Are you a Political Exposed Person or related to Political Exposed Person: Yes <input type="checkbox"/> No <input type="checkbox"/>	
(appropriate tick) If Yes, give details _____	
Note: Politically Exposed Persons” (PEPs) are individuals who are or have been entrusted with prominent public functions domestically/in an international organisation/in a foreign country. This would include individuals who have or had positions of Heads of States or Government, Senior Politicians, Senior Government or Judicial or Military officers, Senior Executives of State-Owned Corporations and important Political Party Officials.	
Type of Organization	
<input type="checkbox"/> Corporation: <input type="checkbox"/> Governments <input type="checkbox"/> Society <input type="checkbox"/> Private Organizations <input type="checkbox"/> International Organization:	
<input type="checkbox"/> Partnership: <input type="checkbox"/> Trust: <input type="checkbox"/> Others:	

Any refund due on the premium payment / any payment / claims will be directly credited to my aforesaid Bank Account*.

*As per the IRDAI, it's mandatory that all payments made to the insured are only through electronic mode.

Note:

1. Please provide a cancelled copy of cheque of your bank account.
2. The Company will not be responsible in case of non-credit or delay in processing of payout due to incomplete/ incorrect information provided by the customer. Please ensure that you provide accurate details to the Company.

If you require physical copy of your policy in future, please visit “Help” section on www.hdfcergo.com or contact our customer care.

Note: The liability of the company does not commence until the acceptance of the proposal has been formally intimated by the Proposer and full premium has been realized by the company. We are under no obligation to accept any proposal for insurance. The Applicant agrees that the receipt of the Proposal Form by HDFC ERGO General Insurance Company Limited along with the premium payment does not tantamount to the acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Limited and does not result in a concluded contract of insurance. The acceptance of the Proposal for insurance shall be at the Company’s sole and absolute discretion and upon full realization of the premium payment. In the event of acceptance of the Proposal for insurance by HDFC ERGO General Insurance Company Limited, such acceptance shall be specifically intimated to the Applicant by HDFC ERGO General Insurance Company Limited along with the date from which the insurance Cover shall become effective. HDFC ERGO General Insurance Company Limited shall not be liable for any claim in respect of an event giving rise to a claim covered under the Policy of Insurance that has occurred prior to policy issuance is not covered under this Policy (Your proposal form will be considered after HDFC ERGO General Insurance Company Limited receives premium payment).

Insurance is the subject matter of the solicitation**B. DECLARATION BY PROPOSER/ INSURED/ REPRESENTATIVE (in case proposer is disabled)**

I/We, the undersigned, declare and acknowledge:

- I/We hereby declare that the information given is, to the best of our knowledge and belief, correct and that we are not aware of any circumstances that we have not disclosed to you which might influence your assessment of and willingness to accept the risk.
- I/We hereby agree that, if you issue a policy to us, this proposal shall form the basis of, and be incorporated in, such policy.
- I/We agree that this declaration and the answers given above shall be the basis of the contract between me/us and the Company and shall be deemed to be incorporated in such contract. And that if any untrue statement be contained therein the said contract shall be absolutely null and void.
- I/We undertake to exercise all reasonable and ordinary precaution for the safety as desired and I/We agree to accept the policy in the form issued by the Company subject to the terms exceptions and conditions prescribed therein or endorsed on the policy.
- “I/We hereby understand, declare, consent and authorize HDFC ERGO General Insurance Company Ltd. that financial information, as provided to the Company may be utilized for processing the claim made under the Policy.
- I/We hereby also understand, declare and consent that the Company shall have right to retain and disseminate the same to any service provider for providing services related to insurance”
- I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been/will be paid out of proceeds of crime related to any of the offence as listed in Prevention of Money Laundering Act, 2002 & its subsequent amendments thereof. I understand that the Company has the right to call for documents to establish sources of funds.

- I, hereby grant consent to Agent/Broker/Corporate Agent or any other licensed intermediary to share my KYC (Know your Customer) and customer due diligence information with HDFC ERGO General Insurance Company Limited for the purpose of my insurance proposal.
- I hereby authorize the Company to notify me through email, SMS, or any other electronic mode any information pertaining to my proposal, policy document, claim servicing etc.
- I/ We authorize the Company to process my/ our Personal as well as Sensitive information for profiling purposes and to contact me/ us for renewal of my/our policy. I/We also authorize the Company to contact me/us (including overriding my/our registration on NDNC under the extant TRAI Regulations) to promote products and to notify me/us about the services being rendered by the Company.
- I/We will abide by the provisions of IRDAI Guidelines on Group Insurance Policies dated July 14, 2005 and subsequent amendment made to it and/ or any other regulations/ guidelines issued by the IRDAI for Group Insurance Policies
- We hereby authorize the Company to share/ verify the information provided by me/us pertaining to my proposal with third party, rating agencies or service provider for the purpose of underwriting the proposal, issuance of a policy or settling of a claim under the policy.

Place: _____

Date:

Signature of the Proposer/Representative
(in case proposer is disabled)

VERNACULAR DECLARATION

Declaration in case the proposal is filled other than the Proposer / the proposer sign in vernacular language / proposer is not familiar with the language printed here/ proposer is illiterate (to be certified by someone other than agent/employee of the company)

(The content of this form and its particulars have been explained by me in vernacular to the Proposer who has understood and confirmed the same.)

Name of the Translator: _____

Place: _____

Date:

Signature of the Translator

Name of the Proposer: _____

Place: _____

Date:

Signature of the Proposer

INTERMEDIARY DECLARATION

I, _____ (Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Intermediary/Authorized employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in this Proposal Form to questions contained herein or any details sought here in will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/information/response(s) is/are contained in this Proposal Form/ including addendum(s), affidavits, statements, submissions, furnished/ to be furnished, the company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/ her favor pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

Place: _____

Date:

D	D	M	M	Y	Y	Y	Y
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Signature of Intermediary

Time: _____

INSURANCE ACT 1938 SECTION 41- PROHIBITION OF REBATES

No person shall allow or offer to allow either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.

ANY PERSON MAKING DEFAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO TEN LAKHS RUPEES.