MEDICAL MALPRACTICE INSURANCE FOR INDIVIDUAL DENTIST

Application Form

Global Professional and Financial Risks

A division of Lockton Companies (Hong Kong) Ltd

IMPORTANT NOTICES TO APPLICANTS

1. This is an application for insurance which contains several insuring agreements. Certain insuring agreements provide coverage on a "**claims made and reported**" or on an "**incident discovered and reported**" basis. The insurance to which this application applies, only applies to such claims or incidents which are first made against or discovered by the insured and reported to insurers during the period of insurance or any applicable extended reporting period.

2. **LOCKTON'S BUSINESS PRINCIPLES**:

   In the absence of a more specific agreement between you and Lockton, your relationship with Lockton will be governed by our Business Principles. Our Business Principles may be amended by us without notice to you and the prevailing version of our Business Principles, as posted on our web site from time to time supersedes any previous version of Our Business Principles. We would urge you to read our Business Principles carefully. If you do not wish our relationship to be governed in such a manner, please advise us in writing before we proceed to arrange your insurance.

3. **YOUR DUTY TO DISCLOSE MATERIAL INFORMATION**:

   Under the law, **you have a duty to disclose** to the insurer all material information relating to the insurance under consideration and all information you provide must be both complete and accurate. "Material" refers to all information, which a prudent insurer would wish to take into account when considering whether or not to accept the insurance and, if so, upon what terms and at what price. If there are any changes to the information you have supplied to the insurer you must also disclose that as your duty continues up until the insurance has been concluded and "resurrects" in the event of any amendment to the insurance during the period of insurance or any extension or renewal. In the event that there is a breach of the duty of disclosure, the Insurer has the right to avoid the insurance from its commencement. **If you are in any doubts as to the ambit of the duty of disclosure or whether a piece of information ought to the disclosed, please contact us**.

4. **REMUNERATION DISCLOSURE:**

   Unless we have specifically agreed with you on the manner in which we will be remunerated for our services, the following statement shall apply to each and every insurance transaction we handle on your behalf: "Lockton Companies (Singapore) Pte Ltd ("the Company") is remunerated for its services by the receipt of commission paid by insurers. Your agreement to proceed with this insurance transaction shall constitute your consent to the receipt of commission by the Company."

LOCKTON

DETAIL OF APPLICANT

Full Names				
Date of Birth:		Gender:	☐ Male	☐ Female
Address:				
E-mail Address:		Tel:		

	Yes	No
1. Is applicant duly licensed in accordance with law to practice in Hong Kong	☐	☐

2. Where do you practice?	☐ Hospital	☐ Private Clinic	☐ Other

3. Are you a member of any dental related association? If yes, please list

Association Name	Association Number

4. Please provide the details of your registration below

Licensing / Registration Body:			
Registration Number:		Registration Type:	
Registration Date:		Date of first Registration:	

5. Other Registration Details (where applicable).

	Yes	No
Have you ever had any of the above declared in questions 4 and 5 refused, suspended, withdrawn or had conditions imposed at any time? If Yes, please provide details on a separate sheet, noting the Section number.	☐	☐

APPLICATION FOR COVER

1. Period of Insurance being applied: From To:

2. Enrollment

Categories	Please put "✓" in the appropriate box below
Dental Hygienist	☐
General Dentistry	☐
Specified Procedures in Private Practice – Level 1	☐
Specified Procedures in Private Practice – Level 2	☐
Specified Procedures in Private Practice – Level 3	☐

LOSS OF INCOME INSURANCE (OPTIONAL)

If you are interested in applying for the Loss of Income Insurance, please provide	Yes	No
1. Gross Annual Income:		
2. Have you ever made an application for accident, sickness, disability, hospital or life insurance which has/have been declined, postponed or withdraw; or has any policy or certificate of such insurance issued to them been modified, rated up, cancelled or renewal refused?	☐	☐
3. Is informed consent obtained from each patient and documented in their medical record?	☐	☐
4. Have you ever made any claims for accident, sickness, disability, hospital or life insurance in the last 3 years, and in what amount were the claims settled?	☐	☐
5. Do you have any physical defects, impairment, deformities and/or conditions affecting mobility, sight and/or hearing	☐	☐
If you had answered Yes to any of the questions in this section, please provide full details in a separate sheet of paper		

INSURANCE HISTORY

	Yes	No
1. Has applicant previously been insured / covered by any insurer? If Yes, please provide details.	☐	☐

Period of Insurance	Insurer	Policy Limit (HKD)	Excess(HKD)	Retroactive date

2. Have you ever had any application for medical malpractice insurance refused, or had any medical malpractice coverage rescinded or cancelled? If Yes, please provide brief details on a separate sheet, noting the Section number.	☐	☐

CLAIM DETAILS

	Yes	No
1. During the past five (5) years, have you ever been subject to disciplinary proceedings for professional misconduct?	☐	☐
2. During the past five (5) years, have any claims for negligence or breach of professional duty ever been made against you, or have circumstances been notified to insurers/medical protection societies that might give rise to a medical malpractice claim?	☐	☐
3. Are you aware of any medical malpractice claim or circumstances that might give rise to a medical malpractice claim against you in which matter is not referred to question above?	☐	☐
4. During the past five (5) years, have you ever been refused enrollment/renewal, or been offered limited/conditional/special terms, or been required increased rate/premium by any medical professional society/association, medical protection society or medical malpractice insurer?	☐	☐

If you had answered Yes to any of the questions in this section, please provide full details and the status of each claim, lawsuit, allegation or matter, including:

- the date of the claim, suit or allegation
- the date you notified your previous insurers
- the name of the claimant(s) and the establishment(s)
- the allegations made against you
- the amount claimed by the claimant(s)
- whether the status is outstanding or finalized
- the amounts paid for claims and defence costs to date

APPLICATION FOR INSURANCE COVER

1. Options (Please indicate required limit / excess)

☐ HKD 5 Million	☐ HKD 10 Million	☐ HKD 25 Million	☐ Other:	☐ Excess:
2. Retroactive Date				

DECLARATION

The undersigned authorized representative of the Applicant declares that the statements set forth herein are true. The signing of this application does not bind the undersigned or the insurer to complete the insurance. It is represented that the statements contained in this application and the materials submitted herewith are the basis of the contract should a policy be issued and have been relied upon by the insurer in issuing any policy. The insurer is authorized to make any investigation and inquiry in connection with this application as is reasonable and necessary. Nothing contained herein or incorporated herein by reference shall constitute notice of a claim or potential claim so as to trigger coverage under any contract of insurance.

This application and materials submitted with it shall be retained on file with the insurer and shall be deemed attached to and become part of the policy if issued. It is agreed in the event there is any material change in the answers to the questions contained in this application prior to the effective date of the policy, the Applicant will notify the Insurer in writing and any outstanding quotations may be modified or withdrawn at the insurer's discretion.

Must be signed by a corporate officer with authority to sign on the Applicant's behalf.

Signed: _____ **Print Name:** _____

Title: _____ **Date:** _____