

POLICY # _____



S/REP.# _____ MAJ# _____

APPLICATION FOR PROFESSIONAL INDEMNITY COVERAGE

BY THE MEDICAL ASSOCIATION OF JAMAICA INSURANCE FUND (MAJIF)

- a) An answer must be given to all questions.
- b) If insufficient space is provided to answer a question insert 'see attached' and show question number and answer on a separate sheet of paper.
- c) Please tick the appropriate box, 'YES/NO' as applicable.
- d) This application will be considered incomplete unless all questions are answered and the form signed in ink by the applicant. Signing the form does not bind the applicant or Medical Association of Jamaica Insurance Fund (MAJIF) to complete the insurance.

APPLICATION TYPE: NEW REINSTATEMENT : If this the first reinstatement? Yes [] / No []

SURNAME	FIRST	MIDDLE
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1. ADDRESS OF PRACTICE: _____

MAILING ADDRESS (If different from above): _____

TELEPHONE NOS.: (W) _____ (H) _____ (C) _____ FAX: _____

SEX: MALE FEMALE E-MAIL ADDRESS: _____

NAME & ADDRESS OF MEDICAL SCHOOL: _____

DATE OF BIRTH: ____/____/____
(dd / mm / yyyy)

2. YEAR OF GRADUATION: _____ NUMBER OF YEARS IN PRACTICE: _____

INTERNSHIP DATES: ____/____/____ (dd/mm/yyyy) PLACE: _____

____/____/____ (dd/mm/yyyy) _____

____/____/____ (dd/mm/yyyy) _____

3.

POST INTERNSHIP TRAINING	DATES	PLACE

QUALIFICATIONS: _____

4. Are you registered with the Medical Council of Jamaica?

YES

NO

Registration Number: _____ Expiry Date: ___/___/___ (dd/mm/yyyy) Specialty: _____

Please supply copy of current Registration Certificate with application.

Sub-specialty: _____ Primary Hospital Affiliation: _____

5. Would you need to do any of the following:

a) Practice outside Jamaica?

YES

NO

If yes, specify: _____

b) Have coverage outside Jamaica?

YES

NO

If yes, specify: _____

6. Do you do any of the following:

a) Laser Surgery?

YES

NO

If yes, specify: _____

b) Laproscopic Surgery?

YES

NO

If yes, specify: _____

c) Liposuction?

YES

NO

If yes, specify: _____

d) Transplant Surgery?

YES

NO

If yes, specify: _____

e) Order or perform Blood Transfusions?

YES

NO

If yes, specify: _____

f) Any form of experimental Surgery?

YES

NO

If yes, specify: _____

g) New drug trials?

YES

NO

If yes, specify: _____

7. Do you now carry Professional Indemnity Coverage?

YES

NO

If yes, company: _____

Expiration Date: ___/___/___ (dd/mm/yyyy) Policy No.: _____

8. Have you ever been declined Professional Indemnity Coverage?

YES

NO

If yes, state reason: _____

9. Have you ever had your Professional Indemnity policy cancelled, refused at Renewal or had special terms imposed?

YES

NO

If yes, state reason: _____

10. Have you ever had a medical negligence suit against you? YES NO If yes, give details: _____

11. Do you have any medical negligence suits pending against you? YES NO If yes, give details: _____

12. Are you aware of any circumstances that may result in medical negligence claim being made against you? YES NO If yes, please state: _____

13. Do you supervise Ancillary Technical Personnel? YES NO If yes, give details: _____

14. Please indicate amount of coverage required: \$50.0m \$25.0m \$15.0m \$5.0m

15. State proposed commencement date of cover: ____/____/____ (dd/mm/yyyy)

I HEREBY DECLARE: that the above statements and particulars are true and that I have not suppressed or misstated any material facts and I agree that this Proposal Form and any supplementary information sheet(s) attached hereto shall be the basis of the contract with Medical Association of Jamaica Insurance Fund (MAJIF).

SIGNATURE

____/____/____ (dd/mm/yyyy)
DATE

FOR OFFICAL USE ONLY

COVERAGE DESCRIPTION	LEVEL	REINSTATEMENT CHARGE	ANNUAL PREMIUM
1. Professional Indemnity	\$		\$
TOTAL PREMIUM DUE			

AUTHORIZED SIGNATURE

DATE