Docsea Services Private Limited

C.O. J-63, Kartar Nagar, 3/1/2, Pusta Shastri Park, Delhi- 110053
Mob: 09368395359,09259117428
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MEMBERSHIP FROM FOR MEDICAL ESTAB.

In Business Arrangement With a leading Insurance Company Of India

Memberhip Date

Date Month Year

Branch: .....

Code:.....

I/we the owner (s) / Director (s) Prop. of M/s.....
I hereby Voluntary agree to be a member of **DOCSEA** Services Private Limited and I am depositing Rs.....for .....years as per details given below towards the expenses to be incurred on Professional Indemnity Insurance Coverage, as provided under the policy and scheme of **DOCSEA SERVICES PRIVATE LIMITED.**

Amount	D/D or A/C Payee/ Cheque No.	Date	Bank	Drawn

Particulars:

Name of Medical Estab.

Owner / Director/ Prop.

Address: Hospital/Nursing Home/ Diag. Center:

State the number of employees (Including visiting doctors)

General Physicians Trainees

Plastic Surgeons Voluntary Workers

Dentists Other (Please Specify)

Pharmacists Specialists including Surgeon in different discipline

Technicians a) EYE/ENT b) Pathologists c) Anaesth

d) Radiologists e) Cardiologists f) Gynaecologist

Do You have Ambulance, if Yes Specify number

Number of OPD Number of IPD Number of Beds

Telephone No. Clinic Residence:

Mobile: E-mail:

Medical Registration No. Year:

Other Particulars (if any).....

I/we hereby declare that I/we have fully understood the policy/scheme and shall abide by the rules and regulations of Docsea Services Private Limited, In case of non-payment in full in time, the Docsea Services Private Limited will have the right to forfeit the amount deposited by me/us.

Signature of Owner/Prop./Director of Med. Estab. Signature of Executive/ Promoter

UNITED INDIA INSURANCE COMPANY LTD.

(A Govt. of India Undertaking)
Regd. & Head Office : united India House, 24 whites Road, Chennai- 6000140
"PROPOSAL FORM FOR MEDICAL ESTABLISHMENT
ERRORS & OMMISSIONS INSURANCE
(DOCSEA)

This Proposal must be Signed. All question must be answered, The Completion and Signature of this proposal does not bind the proposer or insure to complete a contract of insurance.
If the space is insufficient to answer questions, please use additional sheets and attach it to this form
The Company does no assume any liabilities until the proposal has been accepted and premium paid

1. Name of the Proposer:
   Address:
2. Year I an which established:
3. Names & Addresses f owners/directors/partners:
4. Have you complied with all statutory rules/
5. Are the Doctors/Nurses/Technicians working for you
   (a) Duly licenced in accordance with the Medical act or any other prevalent laws
   (b) Members of medical Association/Council
6. State the number of employee (including visiting) doctors) in act of the following classifications)

1.	General Physicians	Specialists including Surgeons in different diciplines	
3.	Plastic Surgeons	a)	EYE/ENT
4.	Dentists	b)	Pathologists
5.	Pharmacists	c)	Cardiologists
6.	Technicians	d)	Radiologists
7.	Nurses	e)	Orthopaedics
8.	Trainees	f)	Gynaecologist
9.	Voluntary workers	g)	Psychiatrist
10	other (Please specify)	h)	Neurologist
		i)	Paediatrician
		j)	Urologists
		l)	Dermatologist
		m)	Oncologist
		n)	Anaesthetists

7. (a) Please Specify all the facilities available like X -ray Scanning, pathology etc.
   (b) Whether persons operating these are qualified and well experiences
8. Do you have Ambulance If yes, Specify number
9. Do you have out patients departments
   Please specify estimated No. of patients to be treated in a year
10. State : No of beds maintained
    No. of Dassinetted for maternity cases
11. Estimated No. of in-patients (actual)
    Previous year: estimated current year)
    to be treated in a year

		PREVIOUS YEAR (Annual)	CURRENT YEAR (Estimated)
a.	General		
b	Medical		
c.	Surgical		
d.	Any other class (please specify)		

12. Give details of radioactive treatment facility Specify the material used and precautions taken further for such usage.
13. Do you undertake training of staff.
    A) If yes, Please give details
    b) Nature of supervision over such trainees.
14. Whether food is supplied by you to patients if yes, specify whether it is prepared by you or supplied by outsiders If supplied by you Please specify the measures taken for maintenance of kitchen and other supervisory measures.
15. Do you supply medicines to patients?
16. State/estimated annual income (this include Room charges, Operation theater Rent, Charge for X-ray facilities, Doctors Fees Nursing charges, Medicines, food Surcharges and any other income)
17. Details of claim lodged against the proposer during the past 5 years on account establishment
18. Have you ever insured against liabilities in the past? If so specify the name of the insurer, policy number and period
19. Has any insurer cancelled/ declined/refused to renew your liability insurance or accepted your proposal subject to restrictions
20. Details of any event likely to give rise to a liability claim against you at a future date.
21. State limits of indemnity required for any one year
22. Period of Insurance required from.....to.....
23. Voluntary Excess

I/we hereby declare that the above statement and particulars are true and I/we have not suppressed of misstated any material facts and that at the present time I/we have not reason to anticipate any claim being brought against me/our or any negligee act, error or commission on my/our and against the company and agree that this declaration shall be the basis of the claims between me/us and the insurer I/we also that the indemnity or misconduct committed PRIOR to commencement of this insurance

Date:

Place: SIGNATURE OF PROPOSER