聯豐亨保險有限公司
Luen Fung Hang Insurance Company Limited

澳門宋玉生廣場 398 號中航大廈四樓
No.398 Alameda Dr. Carlos D'Assumpcao,
Edificio CNAC, 4-Andar, Macau.
Tel: (853) 28700033 Fax: (853) 28700088
Website: http://www.luenfunghang.com
E-mail: info@luenfunghang.com

Medical Malpractice Insurance Proposal Form
醫療失誤保險投保書

Individual
個人

Please read the following note before you complete the proposal.
請閣下在填寫本投保書前先閱讀以下投保須知事項。

1. YOUR DUTY OF DISCLOSURE 披露責任

Before you enter into any contract of general insurance with an insurer, you have a duty to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate a contract of general insurance.
在與保險公司訂立保險合同前，閣下有責任向保險公司披露有關任何會影響保險公司考慮可否接受投保、及/或制定條款的一切閣下已知悉、或合理預期應該知悉的信息。閣下在續保、擴展、更改或恢復保險合同前亦對保險公司負有提供相同信息之披露責任。

Your duty does not require disclosure of a matter 該披露責任不包括以下信息：

- that diminishes the risk to be undertaken by the insurer 降低保險公司承保的風險;
- that is of common knowledge 屬於普通知識;
- that your insurer knows or, in the ordinary course of his business, ought to know 保險公司已知悉，或其業務日常營運下應該知悉;
- as to which compliance with your duty is waived by the insurer. 已獲保險公司豁免披露責任的範圍。

Non-disclosure 違反披露責任

If you fail to comply with your duty of disclosure, the insurer may be entitled to reduce his liability under the contract in respect of a claim or may cancel the contract. 若閣下不遵守披露責任，保險公司可減少保險合同之賠償責任或終止保險合同。
If your non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning. 若有關違反披露屬於欺詐行爲，保險公司可決定保險合同由起始日期失效。

2. CLAIMS MADE POLICY 索償基礎保單

THE TERMS AND CONDITIONS of a Claims Made Policy provide that, if a claim is made against you or any notice of an intention to make a claim against you is received or circumstances come to your attention which are likely to cause a claim to be made against you or which you should reasonable expect to cause a claim to be made against you during the term of the Policy then you must immediately notify Underwriters thereof. This notification must be given during the term of the Policy for the Policy to apply. 根據索償基礎保單的條款規定，在保險期限內若閣下接獲任何索償或知悉任何索償意圖的通知或閣下意識可能出現引致索償的情況發生或閣下合理預期引致閣下被索償的情況，則閣下必須立即通知保險公司，該通知並且必須在適用於該保險期限內之保險合同內提出。

The time of happening of the acts or circumstances which give rise to a claim or possible claim is not of relevance provided they occur after the retroactive date stated on the Certificate of Insurance and the relevant sum insured is adequate. Your obligation under the Policy is to communicate to Underwriters during the term of the Policy a claim, notice of a possible claim or circumstance or act which comes to your attention and which may give rise to a claim or which you should reasonably expect may give rise to a claim as soon as is reasonably possible after such is made, received or has come to your attention. 有關引致索償或可能索償之事件或情況，必須發生在保險證明書上的追溯日之後及有關保障金額適當。閣下於本保險合同的責任爲在保險期限內向保險公司通知關於任何索償或可能索償或閣下知悉可能引致索償情況或事件或閣下合理預期可能引致的索償。上述的通知必須在閣下被提起或接獲索償或在知悉後盡快通知保險公司。

Upon expiry of the Policy no further claims can be made thereunder and the need to maintain insurance or to arrange run off coverage is essential.本保險合同不承保在保險合同到期日後所作出之任何索償。請注意維持有效保險的需要或安排持續保障的重要性。

3. UTMOST GOOD FAITH 最大誠信原則

This Insurance is a contract based on the utmost good faith requiring the Insurer(s) and the Proposer / Insured(s) to act towards each other with the utmost good faith in respect of any matter arising in relation to this insurance. 本保險以最大誠信原則爲基礎，保險公司及投保人/被保險人各方相互均必須遵守及以最大誠信原則對待本保險的任何事項。

(Chinese translation is for reference only. Please refer to English version for details. 以上中文譯本只供參考，一切以英文爲準。)

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醫療失誤保險投保書

(Claims Made Basis 以索償爲基礎)

Individual
個人

It is essential that all questions be answered fully. If the answer to any question is None, state "None".
閣下必須確切回答以下所有問題。如問題之答案爲沒有時，請註明 "沒有"

1	Full name of applicant 投保人姓名： English 英文：_____ Chinese 中文：_____ Address 地址：_____ Email 電子郵箱：_____ Tel. no. 聯絡電話：_____
2	Full name of Insured (Please submit ID copy and Name Card) 被保險人姓名(請附上身份證副本及名片)： English 英文：_____ Chinese 中文：_____ License No. (Please submit License copy) 執照編號(請附上執照副本):_____ Expiry date 執照到期日 ：_____ Professional title of the License 執照類別 ：_____ Address 地址：_____ Email 電子郵箱：_____ Tel. no. 聯絡電話：_____
3	Where did you graduate 閣下於何處取得學歷：_____ a) Degree of designation obtained (Please submit copy) 獲取專業資格學位 (請附上副本) b) Date of designation obtained 獲取專業資格日期
4	a) How long have you been practicing? 已執業多久?_____ b) Which of the following medical disciplines you are belonging to: 閣下屬於下列哪一項醫療範疇： ☐ Nurse 護士 ☐ Pharmacist 藥劑師 ☐ Pharmacy Technical Assistant 藥房技術助理 ☐ Therapists 治療師：Type 類型 _____ ☐ Chinese Medicine Practitioner 中醫 ☐ Acupuncturist 針灸師 ☐ Massagist 按摩師 ☐ Chiropractor (Non-procedure) 脊醫 (不施行手術) ☐ General Practitioners (Non-procedure) and but not excluding below Doctor 普通科醫生(不施行手術及不包括以下醫生) Doctor (non-procedure) 醫生(不施行手術)： ☐ Cardiology (non-procedure) 心臟科 (不施行手術) ☐ Anesthetist 麻醉師 ☐ Accident & Emergency 意外及急症科 ☐ Radiology & Radiotherapy 放射科及放射治療科 ☐Dentists 牙科醫生 ☐ Ophthalmologist 眼科 ☐ Otorhinolaryngologist 耳鼻喉科 ☐ Medical Technologist 醫務化驗師 ☐ General Surgery (excluding High Risks as below) 施行外科手術醫生(不包括以下高風險類) High Risks 高風險類： ☐ Gynaecology 婦科 ☐ Obstetrics 產科 ☐ Cardiothoracic Surgery 心臟科手術 ☐ Spine Surgery 脊椎手術 ☐ Neurosurgery 神經外科 ☐ Cosmetic / aesthetic risk 美容矯形類 ☐ Orthopaedic Surgery 整形外科手術 ☐ Plastic & Reconstruction Surgery and Vascular Surgery 整形復原手術及管脈科手術 ☐ Liposuction 抽脂 ☐ Others 其他: _____ .

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5	a. Are you in the employ of any individual or firm? 閣下是否受聘於任何個體或機關? ☐ YES 是 / ☐ NO 否 If "YES" explain 如 "是"，請詳細註明受聘單位名稱_____ Location 地點_____ b. Are you a Partner, Shareholder, Manager or a Legal Representative of the Medical Institutions? 閣下是否醫療場所的合夥人、股東、經理、董事或法定代理人? ☐ YES 是 / ☐ NO 否 If "YES" explain 如 "是"，請詳細註明： Medical Institution License No. 醫療場所執照編號：_____ Name of Medical Institutions 醫療場所名稱_____ Location 地點_____
6	Total number of patients 病人總數 i) During the last 12 months 最近十二個月內_____ ii) In the 12 months prior 上述期間十二個月內_____ iii) Estimate for ensuing 12 months 估計未來十二個月內_____
7	a) Are you currently Insured against Medical Malpractice? ☐ YES 是 / ☐ NO 否 現時是否已具有醫療失誤保險保障? b) If the answer to (a) is NO, has this practice ever been insured? ☐ YES 是 / ☐ NO 否 如(a)答否 – 閣下有否曾經接受該等保險保障? c) If the answer to (a) is YES, please supply following data. 如(a)答是 – 請提供下述資料 - Amount of Cover 保障額 _____ - Amount of Excess 自負額 _____ - Last Annual Premium 最近期之年保費 _____ - When lapsed or if current, the expiry date 保單於何時失效，或現存之保單保障到期日_____ - Name of Insurer 保險公司名稱 _____
8	Do you own or operate a medical clinic? 閣下是否擁有或自營診所? ☐ YES 是 / ☐ NO 否 If "YES", please advise how many registered nurses are employed 若"有"，請註明受聘之註冊護士數目_____ Location 地點 _____
9	Of what professional organizations are you a member? 閣下屬於哪一些專業組織成員? _____
10	Amount of Indemnity required? 請提供閣下投保之賠償金額要求? ☐ MOP500,000 ☐ MOP1,000,000 ☐ MOP2,000,000 ☐ Others 其他 _____ Amount of Excess required? 自負額要求?_____ Effective from 生效日起由 _____(to be confirmed 待確定) for 12 months 共 12 個月
11	a) Has any application for insurance in respect of the practice to be covered ever been declined, cancelled or renewal refused? 閣下有否曾被任何保險公司拒絕、取消受保或拒絕續保有關執業事務之保障? ☐ YES 是 / ☐ NO 否 If "YES" explain 如 "是"，請詳細註明 _____ b) Have any special terms ever been imposed? 有否曾被附加任何特別條款? ☐ YES 是 / ☐ NO 否 If "YES" explain 如 "是"，請詳細註明 _____
12	a) Have any claims of medical malpractice ever been made against you? If so, please provide details of each claim. 閣下有否曾經因爲醫療失誤而被索償? 若有，請提供每宗索償事件之詳情。 _____ b) Are you aware of any circumstances which may give rise to claims against you for medical malpractice, whether you consider yourselves liable or not? If so, please give full details. 閣下有否察覺到可有任何情況因爲醫療失誤而引致有可能被索償事件，閣下認爲自己是否須要承擔責任? 若是，請提供詳情。 _____ Note: Coverage will be excluded for items mentioned in response to (a) and (b). 註：有關(a)及(b)項所提及之項目爲不包括在承受保險範圍內。

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Declaration & Authorization

I declare that the statements and particulars in this proposal are true and that I have not mis-stated or suppressed any material facts. I agree that this proposal together with any other information supplied by me/us, shall form the basis of any Contract of Insurance affected thereon. I undertake to inform the Insurers of any material alteration to these facts occurring before completion of the Contract of Insurance which is deemed to be 0.01 a.m. on the date inception. Signing this Proposal Form does nor bind the Proposer or the Insurer to complete this insurance.

IT IS UNDERSTOOD AND AGREED：

(1) I/We declare that the information stated in this Proposal Form is true and complete and will form the basis of this insurance.
(2) I/We declare that this Proposal Form is applied and signed at Macau Special Administrative Region, in case of fraud or factual misrepresentation, the cover for me/us and/or for the Insured Person(s) may be invalidated.
(3) I/We agree to accept all the terms and conditions of "Medical Malpractice Insurance" Policy.
(4) I/We agree "Luen Fung Hang Insurance Company Limited" ("Luen Fung Hang") reserves the right to accept or decline my/our application.
(5) I/We understand that Luen Fung Hang's liability for myself/ourselves and/or for the Insured Person(s) will only take effect provided that premium has been paid.
(6) The information provided by me/us to Luen Fung Hang is collected to enable Luen Fung Hang to carry on insurance business and may be used for the purpose of：
   - processing and/or approving applications for products and/or services and additions, alterations, variations, cancellations, renewals, and reinstatements of such products and/or services which may include, without limitation, insurance, provident fund or scheme, or other financial products or services;
   - offering and providing products and/or services to me/us from time to time, and administering, maintaining, managing and operating such products and/or services;
   - any claim or investigation, analyzing, processing, assessing, determining or responding of such claims;
   - exercising any right of subrogation;
   - preventing and/or detecting crimes, fraud and other dishonest behavior; and

   may be transferred to the following parties (whether within or outside the Macau Special Administrative Region) for the purposes set out as above：
   - reinsurance and claims investigation companies, relevant insurance industry associations and federations, and members of such industry associations and federations;
   - agents, contractors, business partners, and third party service providers who provide administration, telecommunications, computer, marketing, and/or other services to Luen Fung Hang and/or any of its affiliated companies in connection with the operation of business;
   - any person to whom Luen Fung Hang is under an obligation to make disclosure under the requirements of any law binding on Luen Fung Hang or under and for the purposes of any guidelines issued by regulatory or other authorities with which Luen Fung Hang are expected to comply;
   - any other person under a duty of confidentiality to Luen Fung Hang which has undertaken to keep such information confidential.
(7) I/We understand that I/We have the right to obtain access to and to request correction of any personal information concerning myself/ourselves and/or the Insured Person(s) held by Luen Fung Hang and/or not to use data for direct marketing purpose. Requests for such access can be made to the Human Resources Department of Luen Fung Hang, address: No. 398 Alameda Dr. Carlos D'Assumpcao, Edificio CNAC, 4 Andar, Macau.

IT IS UNDERSTOOD AND IRREVOCABLY AUTHORIZED：

(1) Luen Fung Hang is hereby authorized to obtain access to and/or to verify any data provided by me/us and/or the Insured Person(s) with the information collected by the relevant insurance industry associations and federations, and members of such industry associations and federations from the insurance industry.
(2) any organization, institution, or individual that has any record or knowledge of my/our/the Insured's employment, sick leave records, accident or loss details (of any sorts), health, medical history or any treatment or advice, that when requested by an authorized representative of Luen Fung Hang may disclose any such information. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original

聲明及授權

本人茲聲明於本投保書內所載之陳述及細項均屬確實無訛。本人並同意本投保書聯同其他本人/我們所提供之資料均會成爲日後保單之基礎及其中一部份。於保障開始前，即保險合約生效前，倘發生任何有關此等實情之關鍵性變更，本人保證當如實通知承保人。簽署本投保書並不約束投保人及保險公司對於保障之生效力。

本人/我們明白及同意：

(1) 本人/我們於本投保書內之陳述乃真確無訛，可作爲簽發保單之根據。
(2) 本投保書是本人/我們在澳門特別行政區內簽署，如有任何訛騙或資料失實，本人/我們及/或受保人之保障有失效之虞。
(3) 本人/我們同意接受「醫療失誤保險」保單上所訂的條款及細則。
(4) 本人/我們同意「聯豐亨保險有限公司」(“聯豐亨”)保留一切有關投保書接納與否之權利。
(5) 本人/我們明白必須繳付保費後，聯豐亨對本人/我們及/或受保人之保險責任始行生效。
(6) 本人/我們明白本人/我們提供的資料爲聯豐亨提供保險業務所需，並可能使用於下列目的：
   - 任何與保險或財務有關的產品或服務，包括但不限於保險、理財、退休金或退休金計劃，或該等產品或服務的申請及任何更改、變更、取消、續期及/或復效的申請；
   - 不時向本人/我們推薦及提供產品及/或服務，及執行、維持、管理及營運該等產品及/或服務；
   - 任何索償，或該等索償的調查、分析、處理、評估、釐定或回應該等索償；
   - 行使任何代位權；
   - 防止及/或偵查罪行、欺詐及其他不誠實的行爲；及

   可能移轉予下述各方（無論在澳門特別行政區境內或境外）作爲上述列出目的之用：
   - 任何再保險及索償調查公司、有關的保險行業協會及聯會和該等協會及聯會的會員；
   - 任何向聯豐亨及/或其相關聯公司提供業務運作有關的行政、電訊、電腦、市場推廣及/或其他服務的代理人、承包人、商業夥伴及第三方服務供應者；
   - 根據對聯豐亨具法律約束力的規定，或因監管或其他管理機構所要求聯豐亨遵守的指引，履行對任何人士的披露責任；
   - 任何對聯豐亨有保密責任的人。
(7) 本人/我們明白本人/我們有權查閱及要求更正由聯豐亨持有有關本人/我們及/或受保人的個人資料；及/或要求不將該等個人資料用於直接促銷的用途。如有需要，本人/我們可向聯豐亨人力資源部提出，地址：澳門新口岸宋玉生廣場 398 號中航大廈四樓。

本人/我們明白及授權，且不得撤回：

(1) 本人/我們授權聯豐亨可向有關的保險行業協會及聯會和該等協會及聯會的會員從保險業內收集的資料中查閱及/或核對本人/我們及/或受保人任何資料。
(2) 任何知悉或擁有本人/我們/被保人之工作、病假記錄、意外或損失(任何類別)之詳情、健康狀況、病歷或任何治療或諮詢記錄及曾爲或將爲本人/我們/被保人診治之機構、組織或人士，向聯豐亨透露有關資料。即使本人/我們/被保人死亡或喪失能力，此授權書仍然存有法律效力，而本人/我們/被保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。

Dated this (dd/mm/yyyy): _____ Signature of the Insured: _____
填表日期 (日/月/年) 投保人簽名

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