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

澳門新口岸宋玉生廣場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

Hospitals / Medical Institutions
醫院 / 醫療機構

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。

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

(Claims Made Basis 以索償爲基礎)

Hospitals / Medical Institutions
醫院/醫療機構

1. It is essential that all questions be answered fully. If the answer to any question is None, state "None".
   請回答所有問題，在答案爲否或沒有的情況必須填寫「否」或「沒有」。
2. If you have insufficient space to complete any of your answers, please continue on your headed paper.
   如果本投保書提供的填寫空間不足夠貴機構回答時，請用貴機構的公司信箋繼續回答。
3. This form must be signed and dated by a Partner, Principal or Identified Officer of the Firm.
   本表格必須由合夥人，院長或機構認定的主管人簽署並註明日期。
4. If you have a brochure about your firm's operation(s), please forward a copy with this application.
   如貴機構有印制有關機構業務運作的宣傳小冊子，請將宣傳小冊子副本連同本投保書一併提交。
5. If the firm is a body corporate, " Partners" is deemed to read "Directors".
   如貴機構爲法人團體，則「合夥人」將被視爲「董事」。

1	(a) Full name of Hospital/Medical Institution, etc. (Hereinafter referred to as "The Proposer") 醫院/醫療機構等的全名 (以下簡稱"投保人")	
	(b) How long being operated by present management? 由現行的管理層運作的時間有多久?	
	(c) License No. (Please submit License copy) 執照編號: (請附上執照副本): Expiry date of License 執照到期日期: Professional title of the License 執照類別:	_____ _____ _____
2	Address/es of Premises 業務地址	
3	Name(s) of Owner(s) or Partners, and details of experience/qualifications 擁有人或合夥人的名稱，及詳述其經驗/專業資格	
4	Is the Proposer maintained in whole, or in part, by public or private funds or endowment? 投保人是否由公共或私人的基金或捐款持有全部或部分?	☐YES 是 ☐NO 否
5	Does the Proposer act as a Charitable Institution? 投保人是否以慈善機構模式運作? If so, please state percentage of full charity patients: 如是，請註明獲全面慈善的病人百分比：	☐YES 是 ☐NO 否
6	Is the Proposer duly licensed in accordance with law to practice at the address (es) specified in the answer to Question 2? 投保人是否持有根據法規要求的合法牌照在問題 2 的註明地址經營業務?	☐YES 是 ☐NO 否

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7	Please give brief description of Proposer's activities: 請重點列明投保人的業務活動：			
8	Please state approximate division of your patients between 請說明病人分布在以下科目的大概百分比：			
	(a) General 普通科	%		
	(b) Medical 內科	%		
	(c) Surgical 外科	%		
	i. Elective Cosmetic 醫學美容	%		
	ii. Organ Transplant 器官移植	%		
	iii. Others 其他	%		
	(d) Maternity/Obstetric 婦產/產科	%		
	(e) Communicable Diseases 傳染病	%		
	(f) Geriatric 老年醫學	%		
	(g) Psychiatric 精神病	%		
	(h) Drug/Alcoholics Dependency 藥物/酒精依賴	%		
	(i) Any other classes 任何其他類別	%		
9	Please state number of licensed medical professional, other medical practitioner and non-employees in each of the following classifications:請說明在以下分類的註冊醫療專業人員、其他醫療服務提供者及非員工人數：	Number of employees 員工人數 Licensed medical professional 註冊醫療專業人員	Other medical practitioner 其他醫療服務提供者	Number of nonemployees 非員工人數
	(a) Non-procedural Physicians 不施行手術醫生：			
	i. Medical 內科			
	ii. Others 其他			
	(b) Surgeons 外科醫生			
	i. Cosmetic 醫學美容			
	ii. Orthopedic 骨科			
	iii. Others 其他			
	(c) Anesthetists 麻醉科醫生			
	(d) Obstetricians 產科醫生			
	(e) Gynecologists 婦科醫生			
	(f) Dentists 牙醫			
	(g) Lab/Path Technicians 實驗室/病理技術員			
	(h) Pharmacists 藥劑師			
	(i) Paramedics 護理人員			
	(j) Midwives 助產士			
	(k) Registered Nurses : 註冊護士			
	i. Day 日			
	ii. Night 夜			
	(l) Undergraduate/Student Nurses 本科/見習護士			
	i. Day 日			
	ii. Night 夜			
	(m) Enrolled Nurses 登記護士			
	i. Day 日			
	ii. Night 夜			
	(n) Others (please specify) : 其他（請註明）			
	i.			
	ii.			
	Total 總計：			

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10	Does the Proposer have management procedures designed to locate and remove from patient contact any Insured person or employee infected by contagious disease? 投保人是否有建立管理程序以追尋被傳染病感染的受保人員或員工及禁止他們與病人接觸? If NO, how the Proposer can avoid patient contact with Insured person or employee infected by contagious disease? 若否，投保人如何防止被傳染病感染的受保人員或員工與病人接觸?	☐YES 是 ☐NO 否
11	Does the Proposer ensure that all qualified medical practitioner (whether employed or visiting) who provide medical services for, or use the facilities of the Proposer are members of a recognized medical defense union/association or protection society, or otherwise carry their own malpractice liability insurance covers? 投保人是否確定所有提供醫療服務或使用投保人設施的合資格醫生（包括受僱醫生或訪客醫生）爲公認醫學申辯團體/協會或維護組織的成員，或者持有承保其本人的醫療事故責任保險? If NO, please give details : 若否，請詳細說明： **Please note that this policy is designed to cover claims made against the Proposer.** If cover is also required for claims made against registered medical practitioners or dentists in Macau (whether employed or non-employed) for work performed at the premises of the Proposer. Please supply a list of all doctors/dentists for whom coverage is required stating the Name, Date of Birth, Qualifications and Practice of each doctor /dentist. **請注意，本保險單保障投保人被索償。**如同時需要爲註冊醫生或牙醫（不論受僱或非受僱）在投保人的業務場所的執行工作提供保障，請提供需要保障的全部醫生/牙醫的名單，列明每名醫生/牙醫的姓名，出生日期，專業資格及與實務經驗。	☐YES 是 ☐NO 否
12	Does the Proposer give radium or other radio-active treatment? 投保人是否提供鐳或其他放射性治療? If so, please give details stating by whom treatment is given. 若是，請詳細說明該治療由誰人提供	☐YES 是 ☐NO 否

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13	Does the Proposer render treatment / services to provoke / avoid gravidity / procreation, including operations to produce sterility, in-vitro-fertilization and/or abortions? 投保人是否提供引發/避免妊娠/生殖的治療/服務，包括施行不育，體外授精及流產的手術? If YES, please give details stating whether visiting doctor or employee render treatment / service and number of patients treated in the last 12 months. 若是，請詳細說明訪客醫生或僱員是否有提供治療/服務，及在過去 12 個月內接受治療的病人數目。	☐YES 是 ☐NO 否
14	Does the Proposer render treatment / services for weight reduction? 投保人是否提供減重的治療/服務? If YES, please give details stating whether drugs are used and number of patients was treated in the last 12 months. 若是，請詳細說明是否使用藥物，及在過去 12 個月內接受治療的病人數目。	☐YES 是 ☐NO 否
15	Does the Proposer undertake clinical trials of any kind? 投保人是否進行任何的臨床試驗? If YES, please give details : 若是，請詳細說明：	☐YES 是 ☐NO 否
16	Please state total number of beds maintained 請說明病床數目	Beds 病床 _____ Bassinets/Cribs/Cots 嬰兒床 _____
17	Are Clinics maintained? If so, state: 是否有營運診所? 若是，請說明	
	(a) Kind 種類	
	(b) Whether free, part-pay or full-pay 是否免費，半費或全費	
	(c) Number of 數目	
	i. Employed Clinic Physicians & Dentist 受僱的診所醫生及牙醫	
	ii. Nurses 護士	
	iii. Patients per year 每年病人	
18.	Estimated Gross Annual Income 估計年毛總收入	
19	Has the Proposer any other Professional Indemnity, Malpractice or Public Liability Insurance? 投保人有否投保其他任何的專業責任，醫療事故或公眾責任保險? If so, please give details 若是，請詳細說明 i. Name of Insurer 保險公司名稱	☐YES 是 ☐NO 否 _____

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19	ii. Limit of Indemnity 賠償限額	
	iii. Excess / Deductibles 自負額/免賠額	
	iv. Expiry Date 到期日	
	Has any Insurance Company ever cancelled, declined, refused to renew or only accepted on special terms the proposer's Professional Indemnity, Malpractice or Public Liability Insurance? 投保人是否曾被任何保險公司取消，拒絕受保，拒絕續保或只接受特別條款限制的專業責任，醫療事故或公眾責任保險? If so, please give details : 若是，請詳細說明	☐YES 是 ☐NO 否
	Have any claims or suits for Malpractice or Negligence been made against the Proposer or is the Proposer aware of any circumstances which may result in any such claims being made against the Proposer? 投保人是否曾因爲醫療事故或疏忽而被索償或訴訟或投保人有否察覺可有任何情況可能導致投保人被索償的醫療事故? If so, please give details : 若是，請詳細說明	☐YES 是 ☐NO 否
	(a) Amount of Indemnity required? 請提供賠償金額要求? (i) For number of licensed medical professional (excluding doctor or dentist) 醫療服務提供者人數(不含西醫或牙醫)在： ☐ below 3 persons 3 名或以下 ☐ 4 to 7 persons 4 名至 7 名 ☐ 8 to 10 persons 8 名至 10 名 ☐ over 11 persons 11 名或以上 (ii) For number of licensed medical professional (including doctor and dentist) 醫療服務提供者人數(含西醫及牙醫)在： ☐ below 3 persons 3 名或以下 ☐ 4 to 7 persons 4 名至 7 名 ☐ 8 to 10 persons 8 名至 10 名 ☐ 11 to 20 persons 11 名至 20 名 ☐ over 21 persons 21 名或以上 (iii) For Public or private hospital under Decree Law no. 22/99/M, 30 May 爲衛生局以及五月三十一日第 22/99/M 號法令之私人衛生單位 (b) Amount of Excess required? 自負額要求? (c) Effective from 生效日起由	☐ MOP1,000,000 ☐ others 其他 _____ ☐ MOP1,750,000 ☐ others 其他 _____ ☐ MOP2,500,000 ☐ others 其他 _____ ☐ MOP3,500,000 ☐ others 其他 _____ ☐ MOP2,000,000 ☐ others 其他 _____ ☐ MOP3,500,000 ☐ others 其他 _____ ☐ MOP5,000,000 ☐ others 其他 _____ ☐ MOP7,500,000 ☐ others 其他 _____ ☐ MOP10,000,000 ☐ others 其他 _____ ☐ MOP20,000,000 ☐ others 其他 _____ ☐ MOP _____ From _____ for 12 months 共 12 個月 (to be confirmed 待確定)

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Declaration & Authorization

I am duly authorized to sign this proposal form on behalf of the Proposer.

I have specifically enquired of management and staff, declare that the statements and particulars in this proposal are true and that I/we have not mis-stated or suppressed any material facts. I acknowledge that the Insurer will be relying on this Declaration, the answers given to the questions in the proposal and all information provided by me in deciding whether to issue a contract of insurance, and, if so, the terms of such insurance and the premium charged.

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

本人聲明獲投保人正式授權代表投保人簽署本投保書。

本人，經特別徵詢管理人員和員工，現聲明在本投保書填報的陳述及資料均屬確實無訛，我/我們並無錯誤陳述或隱瞞任何重大事實。本人確認保險公司將依據本聲明書，投保書內問題獲提供的答案及本人提供的所有資料作爲是否決定簽發保險合同，同時，可能作爲訂定保險單條款及收取保險費的根據。

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 填表日期 _____ day of 日_____ month 月 _____ Year 年

For and on behalf of 代表 _____ (Name of Proposer 投保人名稱)

Signature of Partner or Principal 合夥人或院長簽署 _____

(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。)