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

醫療服務提供者職業民事責任強制保險投保書

Compulsory Professional Liability Insurance for Healthcare Providers Proposal Form

醫院 / 醫療機構
Hospitals / Medical Institutions

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

1. 披露責任 YOUR DUTY OF DISCLOSURE

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。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.

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

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

違反披露責任 Non-disclosure

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 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。If your non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning.

2. 索償基礎保單 **CLAIMS MADE POLICY**

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 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.

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。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.

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。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.

3. 最大誠信原則 **UTMOST GOOD FAITH**

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。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.

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(以索償爲基礎 Claims Made Basis)

醫院/醫療機構
Hospitals / Medical Institutions

1. 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」。
   It is essential that all questions be answered fully. If the answer to any question is None, state "None".
2. 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。
   If you have insufficient space to complete any of your answers, please continue on your headed paper.
3. 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。
   This form must be signed and dated by a Partner, Principal or Identified Officer of the Firm.
4. 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。
   If you have a brochure about your firm's operation(s), please forward a copy with this application.
5. 如貴機構爲法人團體，則「合夥人」將被視爲「董事」。
   If the firm is a body corporate, " Partners" is deemed to read "Directors".

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

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

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10	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? Does the Proposer have management procedures designed to locate and remove from patient contact any 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? If "NO", how the Proposer can avoid patient contact with Insured person or employee infected by contagious disease?	☑是 YES ☐否 NO
11	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? 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 medical malpractice liability insurance covers? 若否，請詳細說明： If "NO", please give details: **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。 **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.	☑是 YES ☐否 NO
12	投保人是否提供鐳或其他放射性治療? Does the Proposer give radium or other radio-active treatment? 若“是”，請詳細說明該治療由誰人提供 If "YES", please give details stating by whom treatment is given.	☑是 YES ☐否 NO

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13	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? Does the Proposer render treatment / services to provoke / avoid gravidity / procreation, including operations to produce sterility, in-vitro-fertilization and/or abortions? 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。 If “YES”, please give details stating whether visiting doctor or employee render treatment / service and number of patients treated in the last 12 months.	☑是 YES ☐否 NO
14	投保人是否提供減重的治療/服務? Does the Proposer render treatment / services for weight reduction? 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。 If “YES”, please give details stating whether drugs are used and number of patients was treated in the last 12 months.	☑是 YES ☐否 NO
15	投保人是否進行任何的臨床試驗? Does the Proposer undertake clinical trials of any kind? 若“是”，請詳細說明： If “YES”, please give details :	☑是 YES ☐否 NO
16	請說明病床數目 Please state total number of beds maintained	病床 Beds _____ 嬰兒床 Bassinets/Cribs/Cots _____
17	是否有營運診所 Are Clinics maintained? 若“是”，請說明 If “YES”, please state: (a) 種類 Kind	☑是 YES ☐否 NO
	(b) 是否免費，半費或全費 Whether free, part-pay or full-pay	☑免費 Free ☐半費 Part-pay ☐全費 Full-pay
	(c) 數目 Number of i. 受僱的診所醫生及牙醫 Employed Clinic Physicians & Dentist	
	ii. 護士 Nurses	
	iii. 每年病人 Patients per year	
18	估計年毛總收入 Estimated Gross Annual Income	
19	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? Has the Proposer any other Professional Indemnity, Medical Malpractice or Public Liability Insurance? 若“是”，請詳細說明 If “YES”, please give details i. 保險公司名稱 Name of Insurer	☑是 YES ☐否 NO _____

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19	ii. 賠償限額 Limit of Indemnity	
	iii. 自負額/免賠額 Excess / Deductibles	
	iv. 到期日 Expiry Date	
	v. 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? 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? 若"是"，請詳細說明： If "YES", please give details:	☐是 YES ☑否 NO
	vi. 投保人是否曾因為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? 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? 若"是"，請詳細說明： If "YES", please give details:	☐是 YES ☑否 NO
20	(a) 請提供投保之賠償金額要求： Amount of Indemnity required:	
	(i) 不含西醫或牙醫服務，按自然人醫療服務提供者人數為： Excluding western medicine or dentistry services, according to the number of natural person healthcare providers:	
	☑ 3 名或以下 less than or equals to 3	☑MOP1,000,000 ☐其他 others MOP_____
	☐ 4 名至 7 名 4 to 7	☐MOP1,750,000 ☐其他 others MOP_____
	☐ 8 名至 10 名 8 to 10	☐MOP2,500,000 ☐其他 others MOP_____
	☐ 11 名或以上 more than or equals to 11	☐MOP3,500,000 ☐其他 others MOP_____
	(ii) 含西醫或牙醫服務，按自然人醫療服務提供者人數為： Including western medicine or dentistry services, according to the number of natural person healthcare providers:	
	☐ 3 名或以下 less than or equals to 3	☐MOP2,000,000 ☐其他 others MOP_____
	☐ 4 名至 7 名 4 to 7	☐MOP3,500,000 ☐其他 others MOP_____
	☐ 8 名至 10 名 8 to 10	☐MOP5,000,000 ☐其他 others MOP_____
	☐ 11 名至 20 名 11 to 20	☐MOP7,500,000 ☐其他 others MOP_____
	☐ 21 名或以上 more than or equals to 11	☐MOP10,000,000 ☐其他 others MOP_____
	(iii) ☐ 為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 For Public or private hospital under Decree Law no. 22/99/M, 30 May	☐MOP20,000,000 ☐其他 others MOP_____
	(b) 免賠額要求? Amount of Deductible required?	MOP _____
	(c) 請提供保險之生效日期要求？ Effective date required?	由 日 月 年 (共 12 個月) From _____dd _____ mm_____ yyyy (for 12 months) (待確定 to be confirmed)

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聲明及收集個人資料聲明

本人/我們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/我們並同意本投保書聯同其他本人/我們所提供之資料均會成為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/我們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，可作為簽發保單之根據。
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/或被保險人之保障有失效之虞。
3. 本人/我們同意接受「醫療服務提供者職業民事責任強制保險」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/或被保險人之保險責任始行生效。

您提供的資料，為聯豐亨保險有限公司(“本公司”)提供保險業務所需，並可能使用於下列目的：

1. 處理及審批您的保險申請或您將來提交的保險申請；
2. 執行您保單的行政工作及提供與您保單相關的服務；
3. 分析或調查、處理及支付您保單有關的索償；
4. 發出繳交保費通知及向您收取保費及欠款；
5. 任何與保險有關的產品或服務的任何更改、變更、取消或續期；
6. 就以上用途聯絡您；
7. 本公司行使任何代位權；
8. 其它與上述用途有直接關係的附帶用途；及
9. 遵循適用法律、規則、規例、實務守則或指引規定的要求，或協助相關本地或海外的政府、監管機構執法或進行調查，包括但不限於美國《海外帳戶稅收合規法案》和跨政府協議。

本公司亦可因應上述用途將您的個人資料移轉予下列各方(包括澳門境內或境外)：

1. 就上述用途，向本公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問(包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商)；
2. 處理索賠個案的理賠師、理賠調查員及醫療顧問；
3. 追討欠款的收數公司或索償代理；
4. 保險資料服務公司及信貸資料服務公司；
5. 再保公司及再保經紀；
6. 本公司的法律及專業業務顧問；
7. 任何金融服務供應商的行業協會或聯會。
8. 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
9. 澳門金融管理局；及
10. 法例要求或許可的政府機關。

您在此授權本公司可向行業協會或聯會從保險業內收集的資料中查閱及/或核對您任何資料。此外，經您同意，本公司可能會以其它方式使用及披露您的個人資料。

本公司擬使用您的資料作市場推廣的直接促銷。本公司會遵從《個人資料保護法》內有關直接促銷的規定。若您不同意本公司使用或提供您的資料予其他人士，藉以用於直接促銷，您應通知本公司以行使您不同意此安排的權利。

任何關於查閱及/或更正資料及/或索取關於私隱政策及所持有的資料種類的要求，及/或要求本公司不將該等個人資料用於直接促銷的用途，應以書面向本公司承保部提出，地址為：澳門宋玉生廣場 398 號中航大廈四樓。

Declaration & Personal Information Collection Statement

I/We 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/We 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/We 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 00:01 a.m. on the date inception. Signing this Proposal Form does nor bind the Insured 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 “Compulsory Professional Liability Insurance for Healthcare Providers” 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.

The information you provide to Luen Fung Hang Insurance Company Limited (“the Company”) is collected to enable the Company to carry on insurance business and may be used for the purpose of:

1. processing and evaluating your insurance application and any future insurance application you may make;
2. administering your insurance policy and providing services in relation to your insurance policy;
3. analysis or investigating, processing and paying claims made under your insurance policy;
4. invoicing and collecting premiums and outstanding amounts from you;
5. any alterations, variations, cancellation or renewal of any insurance related product or service;
6. contacting you for any of the above purposes;
7. exercising any right of subrogation;
8. other ancillary purposes which are directly related to the above purposes; and
9. complying with applicable law, rules, regulations, codes of practice or guidelines or assisting with law enforcement purposes, investigations by policy or other government or regulatory authorities in Macau or elsewhere; including but not limited to FATCA and the IGA.

The Company may disclose your personal data for the above purposes to the following classes of transferees who may be located in Macau or outside of Macau:

1. third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist us to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
2. in the event of a claim, loss adjudicators, claims investigators and medical advisors;
3. in the event of default, debt collectors and recovery agents;
4. insurance reference bureaus or credit reference bureaus;
5. reinsurers and reinsurance brokers;
6. the Company’s legal and professional advisors;
7. any financial services provider industry association or federation;
8. any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
9. the Monetary Authority of Macao; and
10. government agencies and authorities as required or permitted by law.

The Company is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the “industry association or federation” from the insurance industry. Moreover, the Company may also use and disclose your personal data otherwise with your consent.

The Company intends to use the data subject’s data in direct marketing. The Company will comply with the provisions of the Personal Data Protection Act. If you do not wish the Company to use or provide to other persons your data for use in direct marketing, you may exercise your opt-out right by notifying the Company.

The person to whom requests for access to data and/or correction of data and/or for information regarding policies and practices and kinds of data held and/or not to use data for direct marketing purpose are to be addressed to the Underwriting Department of the Company at No.398 Alameda Dr. Carlos D’ Assumpção, Edifício CNAC, 4º Andar, Macau.

填表日期 Dated this _____ 日 day of_____ 月 month _____ 年 Year

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

合夥人或院長簽署及蓋章 Signature of Partner or Principal with Chop_____

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