POLICY # _____ S/REP. # _____ MAJ # _____

APPLICATION FOR PROFESSIONAL INDEMNITY COVERAGE

BY THE MEDICAL ASSOCIATION OF JAMAICA INSURANCE FUND (MAJIF)

PHARMACISTS

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

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 Pharmacy Council of Jamaica?** YES NO

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

Please supply copy of current Registration Certificate with application.

5. **Is your place of practice registered with the Pharmacy Council of Jamaica?** YES NO

If no, please say why: _____

Registration No.: _____ Expiry Date: _____

Please supply copy of current Registration Certificate with application.

6. **Do you now carry Professional Indemnity Coverage?** YES NO **If yes, company: _____**

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

7. **Have you ever been declined Professional Indemnity Coverage?** YES NO **If yes, state reason: _____**

8. **Have you ever had your Professional Indemnity policy cancelled, refused at Renewal or had special terms imposed?** YES NO **If yes, state reason: _____**

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

10. **Do you have any professional negligence suits pending against you?** YES NO **If yes, give details: _____**

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

12. **Do you supervise Ancillary Technical Personnel? Ex., Pharmacy Technicians** YES NO **If yes, give details: _____**

13. Amount of coverage required: **$5.5M**

14. 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).

_____ _____/_____/_____ ***(dd/mm/yyyy)***

SIGNATURE **DATE**

FOR OFFICAL USE ONLY

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

_____ _____

AUTHORIZED SIGNATURE **DATE**