

MEMBERSHIP APPLICATION SCHEME OF CO-OPERATION MALAYSIA

1 800 81 5837 | insurance@mma.org.my | medicalprotection.org

Medical
Protection



Please complete all parts of this form in **BLACK INK** and **BLOCK CAPITALS** and return to: **Malaysian Medical Association, 4th Floor MMA House, 124 Jalan Pahang, 53000 Kuala Lumpur, Malaysia.**

If your application for membership of MPS is approved, it will be dated from the day following receipt of your application unless you specify a later start date in the box to the right: (DD/MM/YYYY)

D	D	M	M	Y	Y	Y	Y
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Section A – Personal details

Title	_____
First name	_____
Surname	_____
Maiden/previous name if any	_____
Date of birth (DD/MM/YYYY)	_____
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Nationality	_____
Membership category (see Membership grade sheet)	_____
Which hospital are you working in? (If applicable)	_____
MMC Registration no. and date of registration. Your application may be delayed if this is not provided.	_____
MMC No.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Any specialist registration?	_____
Date of specialist registration	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Country of practice	_____
Country of permanent residence	_____
Address for correspondence	_____ _____ _____
Postcode (zip or postal area)	_____
Email address	_____
Daytime telephone	_____
Evening telephone	_____
Cell number	_____
Fax number	_____
Degrees and diplomas	_____
Basic	_____
Postgraduate	_____
Medical school and country	_____
Month and year of graduation	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

IMPORTANT! – Please read the following

1. As part of our normal process, we may approach your previous indemnity or insurance organisation for your claims history. This process will take a minimum of 15 working days.
2. Failure to disclose full and accurate details about your previous history, practice and income may invalidate your membership which means you are not entitled to seek advice or assistance from MPS.
3. When completing the previous history section on pages 2 and 3 you must account for any gaps in your indemnity or insurance history during the last 10 years and also any break in clinical practice during the previous 2 years.
4. We will not assist with any matter arising from an incident pre-dating your MPS membership.
5. If you are leaving a claims made insurance contract, please ensure you have notified your previous provider of any adverse incident of which you are aware, that could become a claim. You should also check with the provider whether any closing payment is required to secure "run-off" cover for any future claim which may arise from an incident pre-dating your MPS membership.

Please note that signing the declaration on page 7 indicates acceptance of the following requirements:

Members undertake to keep MPS informed of their current address and any changes in their professional circumstances. Failure to notify us of any change of address or scope of practice could result in the suspension and/or the withdrawal of the benefits of membership and/or the cancellation and/or the termination of your membership. Members should understand that MPS is not an insurance company. The benefits of MPS membership are granted at the discretion of Council and are subject to the terms and conditions of the MPS Memorandum and Articles of Association, as amended from time to time.

The Medical Protection Society Limited (MPS) is a company limited by guarantee registered in England with company number 36142 at 33 Cavendish Square, London, W1G 0PS. MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS is a registered trademark and 'Medical Protection' is a trading name of MPS.

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Section B – Previous History  PLEASE READ THE IMPORTANT INFORMATION BELOW

In this section you must include details of any matter in which you have been named or involved. Please include any pending, unresolved or closed issues, even those already reported to MPS. If necessary please continue your answers on pages 4 to 6. Please note that failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

1. Have you had any professional indemnity/insurance before? Yes (Please go to Q2) No (Please go to Q4)

2. Please give the name of all other organisations and the dates during which you were a member or policyholder. If you were previously a member of MPS, please give your membership number and your name at the time (if it has changed).

Organisation	From (DD/MM/YYYY)	To (DD/MM/YYYY)	MPS number	Name	Other membership or policy number

3. Have there been any gaps in your professional indemnity (have you practised without indemnity) during the last ten years? (If in doubt please indicate YES.) **If you answer YES please confirm the dates and the reason for any gap below.**

Yes No

4. Have there been any breaks in your clinical practice in the last 2 years? (If in doubt please indicate YES.) **If you have answered YES please confirm the dates and the reason for any gap. Please also provide details of any continuous professional development or refresher training that has been undertaken.**

Yes No

5. Have you ever been refused professional indemnity/insurance, including refusal to renew or been offered limited or conditional terms or a higher/enhanced subscription/premium? (If in doubt please indicate YES.) **If you have answered YES please provide a summary in your own words providing dates and reasons, including copies of any correspondence.**

Yes No

6. In the last 10 years have you ever been the subject of any **complaint(s)** arising out of your professional practice **which have not been resolved at local level.** **If you have answered YES please provide full details of the complaint(s). The details must include a summary in your own words of the events leading to the complaint(s), dates, the extent of your involvement and the final outcome.**

Yes No

If you have answered YES to any of the above questions please provide details as requested. Use pages 4 to 6 if needed, include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

7. Have you ever been involved in any **claim** for compensation or damages arising out of your professional practice or are you aware of any incident that might become a claim? (If in doubt please indicate YES.) **If you have answered YES please provide a summary in your own words of the events leading to the claim(s) declared, including dates, the extent of your involvement and also the final outcome.**

Yes No

8. Have you ever been the subject of a disciplinary inquiry by your employer or had practice privileges refused/withdrawn/made conditional by a private health care provider? (If in doubt please indicate YES.) **If you have answered YES please provide a summary in your own words to include dates, the extent of your involvement and also the final outcome. Copies of any associated correspondence must be provided.**

Yes No

9. Have you ever been subject to any referral, complaint, inquiry or investigation or hearing by your registration body or any other registration body or had conditions imposed on your practice or been suspended or erased from a medical register? (If in doubt please indicate YES.) **If you have answered YES please provide a summary in your own words of the events leading to the registration body inquiry/investigation, including dates, the extent of your involvement and you must provide copies of any final determination letter(s).**

Yes No

10. Have you ever been cautioned by the police in respect of, or convicted of, any criminal allegation (including road traffic offences)? **If you have answered YES please provide a summary in your own words to include the nature of the offence, the final outcome or the current position and whether the offence was reported to any registration body.**

Yes No

11. Are there any other issues of which MPS might reasonably need to be aware when considering your application for membership? (If in doubt please indicate YES.) **If you have answered YES please provide all relevant information below.**

Yes No

If you have answered YES to any of the above questions please provide details as requested. Use pages 4 to 6 if needed, include additional pages if required. Failure to disclose full and accurate details about your previous history may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.

If necessary please provide FULL details on additional sheets

Will all your medical practice be carried out in Malaysia? Yes No If No, please give full details:

If you are registered to practise in other countries please state which:

What is your current professional status?

What is your current specialty?

Please indicate your medical status (as per current MPS subscription categories)

- | | |
|--|---|
| <input type="checkbox"/> GPs – core services | <input type="checkbox"/> Medical officer – first year qualified |
| <input type="checkbox"/> GPs – procedural | <input type="checkbox"/> Medical officer – second year qualified |
| <input type="checkbox"/> GPs with obstetrics | <input type="checkbox"/> Medical officer – third year qualified |
| <input type="checkbox"/> Cosmetic/aesthetic medicine | <input type="checkbox"/> Government doctor |
| <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Government doctor and limited private practice |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Non-Clinical (Please provide details of your practice in writing) |
| <input type="checkbox"/> Super high risk | |
| <input type="checkbox"/> Very high risk | |
| <input type="checkbox"/> High risk | |
| <input type="checkbox"/> Medium risk | |
| <input type="checkbox"/> Low risk | |

Scheme specific Information

Identity card number (old)

Identity card number (new)

Are you an MMA member Yes No

IMPORTANT! – Please read the following and sign below

Please note: We require you to tell us about any current claims, complaints (not resolved at local level), previous criminal convictions, disciplinary or similar issues which have not been previously notified to MPS.

Important – Your Personal Information and Data

At times we will ask you to provide us with data and personal information including when you apply for membership, your subscription is renewed, your scope of practice changes and if you seek and we provide assistance to you. In applying for membership and by continuing as a member you agree that (i) we may hold and process your personal data including sensitive personal data (as defined in the United Kingdom's Data Protection Act 1998 (the Act)) which you provide to us or which we fairly obtain from another source for the purposes of processing your membership renewal, the administration and provision of membership services, providing you with the benefits of membership (including, but not limited to, advice, assistance and indemnity), underwriting, risk assessment, marketing, education, research and audit during your membership and for a reasonable period after your membership terminates or an application for membership renewal is rejected by us or withdrawn by you and (ii) we may share such data with third parties who may also hold and process the data for the same purposes. Under the Act you have the right to ask us for a copy of any of your personal data which we hold, for which we make a nominal charge.

You also agree that (i) we may seek information relevant to any purpose for which you have agreed we may hold personal data from other professional defence organisations, insurance companies, employers or other third parties regarding your professional practice and career history and that they may release to us such information, (ii) if you are outside of the European Economic Area (EEA) your data may be transferred to, held and processed within the EEA and (iii) if you provide us with an email address or telephone number it may be used by us and third parties to contact you for any of the purposes for which you have agreed to allow us or them to hold or process your personal data.

IMPORTANT! – Please read, sign and add the current date below.

By signing and returning this form you confirm that:

- (i) You wish to apply for membership of MPS subject to the Memorandum and Articles of Association
- (ii) You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension or withdrawal of membership benefits and/or the cancellation and/or termination of membership
- (iii) You understand that membership is not conferred automatically and is subject to approval by MPS
- (iv) You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS and/or the association does not of itself confirm membership and/or entitlement to request benefits
- (v) You will inform us if your personal circumstances or scope of practice changes

Please check that you have completed a payment instruction form telling us how you would like to pay for your subscription and please tick here to confirm that the form is enclosed.

In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. If you do not wish to receive such information, either via post or email, please tick here.

Signature: _____

Date: DD/MM/YYYY (Please note must be current date)

Please remember to inform us promptly if your personal circumstances or scope of practice change.

Please tell us why you have chosen MPS – Your comments are important to us, please tick below

- 1. Personal recommendation
- 2. Competitive subscription rates
- 3. MPS membership co-ordinator, please provide their initials: _____
- 4. Group arrangement
- 5. Dissatisfaction with previous organisation
- 6. Other (please provide details in the space provided)

Medical Protection – Malaysia

Contact information

A scheme of co-operation between Medical Protection and Malaysian Medical Association

4th Floor MMA House

124 Jalan Pahang, 53000 Kuala Lumpur, Malaysia.

T 1 800 81 5837

F 1 800 81 5840

E insurance@mma.org.my



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