

GROUP MEDICAL PROPOSAL FORM

IMPORTANT

WE will not be on risk until WE have accepted the Proposal and the Medical Declaration and communication of acceptance has been given to the company in writing on full payment of premium.

SECTION 1 - COMPANY DETAILS

Full name of the Company	
Nature of business	
Are you currently insured?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, name of previous/current insurer?	

SECTION 2 - COMPANY ADDRESS

1. Physical Address	
2. Postal Address	P.O. Box No.:
3. Contact Numbers	Telephone: Fax:

SECTION 3 - TYPE OF COVER REQUIRED

If standard, please tick one of the following:			
Requested Effective Date (Must be within 30 days of this proposal)			
<i>If non-standard, please complete Section 9</i>			

SECTION 4 - CLAIMS HISTORY (Past 3 years)

Year	No. of Lives	Total Amount (KD)

SECTION 5: MEDICAL DECLARATION (employees with pre-existing and chronic conditions, etc)

Sr. No	Staff No.	Name of Employee	Disease Details
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

SECTION 6 - ELIGIBILITY

No of employees

No of dependants

SECTION 7: AGE/SEX DETAILS (enter total number to be covered in each category)

Age	Employees		Dependants		Age	Employees		Dependants	
	Male	Female	Male	Female		Male	Female	Male	Female
0-18					42				
19					43				
20					44				
21					45				
22					46				
23					47				
24					48				
25					49				
26					50				
27					51				
28					52				
29					53				
30					54				
31					55				
32					56				
33					57				
34					58				
35					59				
36					60				
37					61				
38					62				
39					63				
40					64				
41					65				

SECTION 8 - COMPANY ADMINISTRATOR DETAILS

Name	
Position	
Telephone	
Fax	

SECTION 9: TAILORED BENEFITS TABLE

Benefits	Options	
	Yes	No
Maternity		
Dental		
Optical		
Pre-existing Conditions		
Others		

SECTION 10 - DECLARATION

I, on behalf of the Company hereby declare and warrant that the above statements are true and complete. I understand that any misinterpretation contained herein would void the contract and any and all claims will be forfeited. I understand that any medical condition that existed prior to the date I am accepted for coverage will be excluded from coverage, whether or not that condition is disclosed on this application. I understand that the insurance company will not be on risk until it has accepted the Proposal and communication of the acceptance has been given to me in writing.

I, on behalf of the Company consent and authorize the Insurer to seek medical information from any Medical practitioner, hospital, clinic, health related facility, pharmacy, insurance agency, insurance company or administrator having advice or documents pertaining to the care, advice, treatment, diagnosis or prognosis of any medical condition.

I, on behalf of the Company agree that this proposal shall form the basis of the contract should the insurance be effected. Upon receipt of confirmation on our quote, the benefits under the quote will be considered the basis for the contract and will remain UNALTERED through out the policy period. If after the insurance is effected, it is found that the statements, answers and particulars stated in the Proposal form and its questionnaires are incorrect or untrue in any respects, the Insurance company shall incur no liability under this insurance.

Authorized Person's Name	
Position	
Date	
Place	
Signature & Company Stamp	