NIC
NATIONAL INSURANCE COMPANY
General Insurance

NATIONAL INSURANCE CO. LTD
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Business Registration Number: C15129641

GROUP COMPREHENSIVE HOSPITALISATION PLAN

Individual Member Proposal Form

For office use only

Proposal Number : _____ Received on : Reviewed by : _____

1. MAIN MEMBER DETAILS (INSURED 1)

COMPANY NAME : _____ **Phone Number :** _____

MAIN MEMBER : Mr/Ms/Mrs (SURNAME/OTHER NAMES) _____ **Plan Details :** _____

Address : _____

Mobile Number : _____ Telephone Number : _____ Email : _____

Height (cms) : _____ Marital Status : _____ Date of Birth : _DD__/ _MM____/ _YYYY__/

Weight (Kg) : _____ Gender : _____ Occupation : _____ NIC :

Were you previously covered under a medical scheme? YES □ NO □

If yes , provide the following details : Name of Insurer : _____ Policy Starting Date : _____ Ending Date : _____

Please provide your bank details for any benefit payable under this scheme.

Name of Bank : _____ Bank Account Number : _____ Branch: _____

Account Holder's Name : _____

2. PROPOSED INSURED DETAILS

Details of Dependants to be insured

Insured 2.Name : Mr/Ms/Mrs _____ **Plan Details :** _____

Height : _____ Relationship : _____ Date of Birth : _DD__/ _MM____/ _YYYY__/

Weight : _____ Gender : _____ Occupation : _____ ID No:

Was proposed insured previously covered under a medical scheme: Yes □ No □

If yes , provide the following details : Name of Insurer : _____ Policy Starting Date : _____ Ending Date : _____

Insured 3.Name : Mr/Ms/Mrs _____ **Plan Details :** _____

Height : _____ Relationship : _____ Date of Birth : _DD__/ _MM____/ _YYYY__/

Weight : _____ Gender : _____ Occupation : _____ ID No:

Was proposed insured previously covered under a medical scheme: Yes □ No □

If yes , provide the following details : Name of Insurer : _____ Policy Starting Date : _____ Ending Date : _____

Insured 4.Name : Mr/Ms/Mrs _____ **Plan Details :** _____

Height : _____ Relationship : _____ Date of Birth : _DD__/ _MM____/ _YYYY__/

Weight : _____ Gender : _____ Occupation : _____ ID No:

Was proposed insured previously covered under a medical scheme: Yes □ No □

If yes , provide the following details : Name of Insurer : _____ Policy Starting Date : _____ Ending Date : _____

Insured 5.Name : Mr/Ms/Mrs _____ **Plan Details :** _____

Height : _____ Relationship : _____ Date of Birth : _DD__/ _MM____/ _YYYY__/

Weight : _____ Gender : _____ Occupation : _____ NIC :

Was proposed insured previously covered under a medical scheme: Yes □ No □

If yes , provide the following details : Name of Insurer : _____ Policy Starting Date : _____ Ending Date : _____

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3. MEDICAL AND LIFESTYLE INFORMATION						
Please answer Y (Yes) or N (No) in the relevant box provided.						
Section A. Have you ever suffered or suffering from any of the following diseases?	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**
a. Diabetes						
b. Paralysis of any kind						
c. Nervous, Mental or Psychiatric disorders						
d. Any heart related disease						
e. any cancer or malignant growth						
f. Spinal Problems						
g. Stomach disorders or gall bladder or kidney stone						
h. Gynaecological disorders						
i. Dental disorders						
j. Hearing disorders						
k. Eye disorders						
k. Suffering from Fistula, Piles, Hernia or Varicose veins						
l. Any other disease or illness not mentioned above						
If yes to any of the above queries, please give details.						
Section B . In respect to the persons to be insured	**1**	**2**	**3**	**4**	**5**	**6**
a. Is there any other issue or condition concerning your health or any complaint in your body requiring attention for treatment or surgery or admission to hospitals or medical interventions?						
b. Are you suffering from any pre-existing diseases, or disorders?						
c. Have you met with any road accident or any other accident leading to bodily injury or hospitalization?						
d. Do you smoke? If yes, please give details on your smoking habit						
e. Do you consume alcohol? If yes, please give details on your drinking habit						
f. Are you presently insured for any type of medical reimbursement policy with any insurance company?						
g. Was any proposal from you declined or cancelled by an insurance company?						
h. Have you ever made or received a claim from any insurance company relating to health or Personal Accident policies?						
i. Are you suffering from any disability or infirmity?						
j. Is there any pursuit or hobby or life style which exposes you to injury or disease?						
If yes to any of the above queries, please give details.						
Family Doctor Details : Name :_____Address:_____Tel:_____Cell:_____						
Section C. Have any of the insured persons involved in any of the activities as under?	**1**	**2**	**3**	**4**	**5**	**6**
Are you involved in any of the activities as under?						
a. Working in Mines						
b. Handling explosives						
c. Involved in electrical installations						
d. Horse riding, bull riding						
e. Skiing, basejumping, free diving , cave diving						
f. Motor racing						
g. Ballooning						
h. Winter sports						
i. Mountaineering						
j. Polo, ice hockey, hunting						

Any other activity similar to the above activities? If yes, please give details.

I hereby declare that the details and particulars provided in this proposal form are true and complete and that I have not withheld any information/material facts that are likely to influence the acceptance and assessment of this proposal.(If you are in any doubt as to whether a fact is material, you should disclose it)
I agree that this proposal shall form the basis of contract between the company and myself and I undertake to provide any information relating to any material change in the particulars mentioned above to the company forthwith.

Important note: No cover is in force until this proposal has been officially accepted by the company, the premium paid and the policy issued, except as may be provided otherwise by an official letter issued at the sole discretion of the company.

Date :_____ Place:_____ Signature :_____