Allied Insurance Company

GROUP HEALTH INSURANCE PROPOSAL FORM

Proposal no.

Policy no.

General Information

Company/ Office Name: _____

Nature of Business: _____

Postal Address (fill below):

House/Building name: _____

Road: _____ District: _____

Postal Code: _____ Atoll,Island: _____

Reg No. | | | | | | | | | | |

Contact Name: _____

Contact No: _____

Email: _____

Fax: _____

Risk Details:

Please provide the list of employees to be insured in the following format:

S.No.	Employee No.(Record Card no.)	Name of the employee	Designation	National ID no. / Passport Number	Nationality	Date of Birth	Specify existing diseases/ conditions, if any

Dependent cover is an optional cover. An additional premium will be charged based on the following information:
(All eligible dependents are required to enroll)

S.No.	Employee No.(Record Card no.)	Name of the employee	Designation	National ID no. / Passport Number	Nationality	Date of Birth	Specify existing diseases/ conditions, if any

Miscellaneous:

Are you currently having an Insurance Policy enforced?

Insured with an Insurance Company? ☐ Yes ☐ No

If **Yes**, period of insurance: From: To:

Claim Ratio of previous policy period: _____

Method of claim Payment:

Account Transfer to Staff- MVR account only
(Account details must be included in the enrollee list)

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 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 consent that the Insurer may hold claims or inactivate Policy in the event of a default of payment.

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 affected, 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.

Declaration: I/We desire to effect with the Company an insurance, in the terms of the Policy used for this class of business and I/We warrant that the above statements and particulars are correct and complete. I/We agree that this proposal shall be the basis of the contract and part of the insurance between myself/ourselves and the Company.

Signature: Date:

Documents required with the Proposal:

☐ Company's registration copy ☐ Enrollee List (Soft Copy in Excel Format)

☐ Passport Size Photo (Soft Copy in .JPG Format) ☐ ID Card / Passport copy (Scanned Copy)

Office use only

Received by: Sign: Date:

THIS INSURANCE WILL NOT BE IN FORCE UNTIL THE PROPOSAL HAS BEEN ACCEPTED BY THE COMPANY

(Acceptance of Proposal means Insurance policy issued and premium collected.)