Allied Insurance Company

Individual Health Insurance Proposal Form

ތަންފަނާ ލަފާދޭ ފޯމް

Proposal no.

Policy no.

☐ Individual ތަނިވަރު ވަނަވަރުން	☐ Company ކުންފުނި
Occupation: ވަޒީފާ	Nature of Business: ވިޔަފާރީގެ ގޮތް
Company/Office/Applicant's Name: ކުންފުނީގެ ނަން/ ދާއިރާގެ ނަން/ ތަންފަނާ ލަފާދޭ ނަން	
Date of Birth: ތުވަކު ދުވަސް D D M M Y Y Y Y	☐ Male ފިރިހެން ☐ Female ތަނިވަރު
Permanent Address (as in ID card): ދާއިމީ ގެއަދަރު (ތަނޑ ކާޑުގައި ހުންނަ ގޮތަށް)	
Postal Address (fill below): ފޯސްޓަލް ތަނ	
House/Building name: ގެއަށް/ ބިއްލިންގ ނަން	
Road: ރޯދ	District: ތަކުރ
Postal Code: ފޯސްޓަލް ކޯޑ	Atoll,Island: ތަކުރ، ނަން

☐ National ID Card ތަނ ކާޑ	☐ Registration Certificate ތަނ ސެޓްފިކެޓ
☐ Work Permit ވޯކ ޕަރމިޓ	☐ Passport ޕާސްޕޯޓ
ID No. ތަނ ނަންބަރ	
Reg No. ތަނ ސެޓްފިކެޓ ނަންބަރ	
Nationality: ދަތުރ	
Contact Name: ގުޅުންހުރި ފަރާތުގެ ނަން	
Contact No: ގުޅުންހުރި ފަރާތުގެ ނަންބަރ	
Email: ޢީމެއިލ	
Fax: ފެކްސ	

Package

SELECT GOLD ☐ SELECT EXCEL ☐ SELECT BASIC ☐

Coverage

INPATIENT ONLY ☐ INPATIENT AND OUTPATIENT ☐

IMPORTANT NOTICE

Please read through the following notes that are relevant to any of either policy you may enroll under.

1. Any of either policy may have a proposer, maximum aged 59 years when applying for the policy.
2. Any of either policy may have a proposer, below 18 years of age, however policy shall be under a legal guardian.
3. Any of either policy proposers may continue health insurance up to the age of 66.
4. All documents of Medical Check-up as per the Check List provided would not be reimbursed under any of either policy.
5. The policy is only for those residing in the Maldives for more than 6 months in a 12 months period. This is not for overseas travelers who remain out of the country for a period more than 6 months.
6. Pregnancy and pre-existing illness will not be covered up to 12 months from policy inception.
7. The policy shall be discontinued if the policy holder fails to disclose a pre-existing illness/condition before the inception of the policy.
8. Policy will be activated after 30 days of waiting period.
9. Policy Coverage is for 12 months period from the issue of Insurance, whereby the policy need be renewed before the end of the period.

Nature of Work
(Please tick whichever is applicable)

Insured ☐ Persons engaged in professional, administrative, managerial, clerical and non-manual operations.

Insured ☐ Persons engaged in work of supervisory nature but not involved in manual labor.

Insured ☐ Persons engaged occasionally or generally in manual work which involves the use of tools or machinery.

Insurance History:

An application for medical or hospitalization type of policy been declined, restricted or accepted at other than normal terms?

If Yes, please state reason and provide the name of the Insurance Company.

Name: _____

Reason: _____

Declaration by Proposer:
(To be read carefully before signing by the Proposer)

I/We hereby declare that the above answers and statements are true, and that I/We have withheld no information whatsoever regarding this proposal. I/We agree that this Declaration and answers given above, as well as any proposal or declaration statement made in here by me/ourselves or anyone acting on my behalf shall form the basis of the contract between me/ourselves and the Insurance Company.

I/We hereby further declare that I/We agree that in the event the declaration shall contain any misstatement, misrepresentation, suppression and or fraud, the issuance of the policy shall not be deemed to be a waiver of such misstatement, misrepresentation, suppression and or fraud.

I/We hereby authorise any hospital, surgeon, medical practitioner or clinic or other person who attended to me/ us for any reason to disclose to the Insurance Company any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/ certifications, including any earlier medical history. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We acknowledge that the liability of the Insurance Company does not commence until this proposal is accepted by and premium paid to the Insurance Company.

I/We also upon filling the form are well aware of the policy I have chosen to enroll in. I/We have also read the Important Notice on the cover page of the proposal form and are aware of their significance and balance in clearly informing of policy limitations.

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.

އަޅުގަނޑު/ އަޅުގަނޑުމެން މި ޕޮލިސީގައިވާ އުސޫލުތަކާއި މާއްދާތަކާއި އެއްގޮތްވާގޮތުގެ މަތިން ތިޔަ ކުންފުންޏާއިއެކު އިންޝުއަރެންސް ހަދަން ބޭނުންވަމެވެ. މި ޕްރޮޕޯސަލް ފޯމުގައި އަޅުގަނޑު/ އަޅުގަނޑުމެން ދީފައިވާ ހުރިހާ މަޢުލޫމާތަކީ އެންމެ ފުރިހަމަ އަދި ސައްޙަ މަޢުލޫމާތެވެ. އަދި މި ޕްރޮޕޯސަލްއަކީ އިންޝުއަރެންސް ފިޔަވަޅުގެ މައިގަނޑު އަސާސް ކަމަށާއި މިޕޮލިސީގެ ބައެއްކަމަށް އަޅުގަނޑު/ އަޅުގަނޑުމެން އިޤްރާރުވަމެވެ.

Signature:	Date:

Office use only		
Rate:	Premium:	Agent's Name:

This form has an **ANNEX A** and **ANNEX B**

Documents required with the Proposal: ފޯމާއި އެކު ހުށަހަޅަންޖެހޭ ތަކެތި	☐ Copy of ID. Card	☐ Pre-Insurance Health Checkup List with Reports
	☐ Medical Examination Certificate (filled and authorized by a Medical Officer)	

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.)

INDIVIDUAL HEALTH INSURANCE

Pre-Insurance Health Checkup

Name: _____ ID No: _____

HEMATHOLOGY

- ☐ Blood R/E and ESR
- ☐ Serum Urea
- ☐ Serum Creatinine
- ☐ Serum Uric Acid
- ☐ Fasting Blood Sugar
- ☐ Post Prandial Blood Sugar
- ☐ Serum Blirubin Total
- ☐ SGPT/ALT
- ☐ Total Cholestrol
- ☐ Serum Magnesium
- ☐ Hepatitis BsAg
- ☐ TSH

Male above 50 yrs

- ☐ PSA Levels

URINE & STOOL ANALYSIS

- ☐ Urine Analysis

IMAGING

- ☐ Chest X ray
- ☐ Whole Abdomen USG

OTHERS

- ☐ ECG 12 leads

Female above 35 yrs

- ☐ Pap Smear
- ☐ Breast Scan

CHILDREN (0-12 YEARS)

- ☐ Blood R/E and ESR
- ☐ Urine Analysis

FOR OFFICE USE ONLY

Date Recieved:

Checked By:

Signature & Stamp:

Note:

- The pre-insurance health checkup can be facilitated for proposer upon request
- Recent medical checkups can be accepted (less than 6 months)
- If an indication arise to further evaluate a specific disease condition, additional diagnostic investigation may be required.
- Expenses incurred for the health checkups shall be borne by the proposer

Allied Insurance Company

MEDICAL EXAMINATION CERTIFICATE

Full Name in BLOCK LETTERS	National ID Card number/Passport Number
Date of Birth: (D/M/Y)	**Sex:** ☐ Male ☐ Female

Please Tick (✓) applicable

		YES	NO
01.	Suffered or have any physical defects, infirmity or congenital conditions?	☐	☐
02.	Currently under observation or receiving treatment or taking any medication	☐	☐
03.	Undergone any surgical operation or suffered any disease or injury?	☐	☐
04.	Ever been advised to have a surgical operation which has not been performed?	☐	☐
05.	Is the person proposed to be insured, pregnant?	☐	☐
06.	Chronic cough, spitting of blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system?	☐	☐
07.	High or low blood pressure, heart disease, chest pain, heart attack, shortness of breath, palpitation or any other heart disorder?	☐	☐
08.	Epilepsy, fits, dizziness, mental or nervous disorder?	☐	☐
09.	Diabetes, sugar or blood in urine, kidney, colic or hernia?	☐	☐
10.	Disease of the eyes, ears, nose or throat?	☐	☐
11.	Arthritis, sciatica, rheumatisms, back, spine, bone, joint, muscle or rectal disorder?	☐	☐
12.	Ulcer or disorder of the stomach. Intestines, hemorrhoids or rectal disorder?	☐	☐
13.	Gall bladder stone or liver disease or any type of hepatitis?	☐	☐
14.	Cancer, tumor or growth of any kind of any organ system?	☐	☐
15.	Anemia, thyroid disorder (such as Goiter) or Rheumatic Fever?	☐	☐
16.	Sexually transmitted disease such as syphilis, gonorrhea, AIDS or AIDS-related conditions?	☐	☐
17.	Non-specific arthritis?	☐	☐
18.	Smoking/Chewing Tobacco?	☐	☐
19.	Any illness or injury not mentioned above?	☐	☐

Allied Insurance Company of the Maldives Pvt. Ltd. (C-43/84), Allied Building, 3rd Floor, Chaandhanee Magu, Male', 20156, Maldives.
1600 +960 332 5035 info@allied.mv www.allied.mv /alliedmv | A subsidiary of State Trading Organization Plc.

If ABNORMAL, details of disability to be listed below, and also state whether it is of a temporary or permanent nature

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EXAMINATION RESULTS

Height (cm)	Weight (kg)	Blood Pressure Syst….. Diast…..	Pulse	Respiration	Hearing Right Ear…… Left Ear….....

Eyesight	
Right Eye	
Left Eye	

INVESTIGATIONS

Blood Group		Hb		Serum uric acid		Serum Bilirubin / Total		Serum Magnesium			
Serum Urea		TC		FBS		SGPT/ALT		TSH			
Serum Creatinine		ESR		PPBS		Total Cholesterol		HBsAG			
ECG						USG					
X-ray						Urine R/E					
Male above 50						**Female above 35**					
PSA level						Pap smear		Breast scan			

CERTIFICATION BY THE MEDICAL OFFICER

I CERTIFY that I have this day examined the above-named, that the results are as set forth

Signature and Qualification of Medical Officer: ……

Full Name in BLOCK LETTERS: …….

Official Designation and Stamp: ……..

Date: …….

Signature of Applicant: ……..

Date: …….

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