



INDIVIDUAL HEALTH INSURANCE PROPOSAL FORM

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Proposal no.

Policy no.

Main form containing fields for Individual/Company selection, Occupation, Nature of Business, ID/Registration/Work Permit/Passport, Date of Birth, Gender, Address, Contact Name, and Contact No.

Package

SELECT GOLD [] SELECT EXCEL (Reimbursement Only) [] SELECT BASIC (Reimbursement Only) []

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.

INDIVIDUAL HEALTH INSURANCE

Pre-Insurance Health Checkup

Name: _____

ID No: _____

HEMATHOLOGY	URINE & STOOL ANALYSIS	IMAGING	CHILDREN (0-12 YEARS)	
<input type="checkbox"/> Blood R/E and ESR <input type="checkbox"/> Serum Urea <input type="checkbox"/> Serum Creatinine <input type="checkbox"/> Serum Uric Acid <input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Post Prandial Blood Sugar <input type="checkbox"/> Serum Bilirubin Total <input type="checkbox"/> SGPT/ALT <input type="checkbox"/> Total Cholesterol <input type="checkbox"/> Serum Magnesium <input type="checkbox"/> Hepatitis BsAg <input type="checkbox"/> TSH	<input type="checkbox"/> Urine Analysis	<input type="checkbox"/> Chest X ray <input type="checkbox"/> Whole Abdomen USG	<input type="checkbox"/> Blood R/E and ESR <input type="checkbox"/> Urine Analysis	
		OTHERS		
		<input type="checkbox"/> ECG 12 leads		
		Female above 35 yrs		
		<input type="checkbox"/> Pap Smear <input type="checkbox"/> Breast Scan		
<th>Male above 50 yrs</th> <td></td> <td></td> <td></td>	Male above 50 yrs			
<input type="checkbox"/> PSA Levels				

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



MEDICAL EXAMINATION CERTIFICATE

Full Name in BLOCK LETTERS	National ID Card number/Passport Number
Date of Birth: (D/M/Y)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

Please Tick (✓) applicable

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

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

EXAMINATION RESULTS

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