



Allied Insurance Company
of the Maldives Pvt Ltd

#04-06 S.T.O. Trade Center, Orchid Magu, Male', Republic of Maldives
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HEALTH INSURANCE PROPOSAL

You are to disclose in this Proposal Form, fully and faithfully, all the facts which you know, otherwise the policy may be invalidated.

Please Choose the Policy of Interest

Individual Plan 2011 Family Plan 2011

If Family Insurance, please specify the number of coverage Clients.

Adult Children (above 12 Years) Children (under 12 Years)

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. Family policy holders may have a dependent spouse of maximum age of 59 years when applying for the policy.
3. Family policy holders may have dependent Unmarried Children under 21 years of age when applying for insurance.
4. Any of either policy proposers may continue health insurance up to the age of 65.
5. Under family insurance, a dependent spouse may continue in the policy till the age of 65.
6. Under family insurance, dependent children may continue policy up to the age of 21 years when unmarried.
7. All documents of Medical Check-up as per the Check List provided would not be reimbursed under any of either policy.
8. 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.
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.

C. Declarations:

1. Do you or any of the persons to be insured have Health Insurance with us or any other company?
If 'Yes', please attach a copy of the existing policy schedule

Yes No

2. Have you or any of the persons to be insured as your dependents:

	Proposer	Spouse	Child	None
A. Suffered or have any physical defects, infirmity or congenital conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Currently under observation or receiving treatment or taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Undergone any surgical operation or suffered any disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Ever been advised to have a surgical operation which has not been performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Have you or any of the persons to be insured as your dependents ever been told that you or they have suffered from or had been treated for any of the following?

	Proposer	Spouse	Child	None
A. Chronic cough, spitting of blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Epilepsy, fits, dizziness, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Diabetes, sugar or blood in urine, kidney, colic or hernia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Disease of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Arthritis, sciatica, rheumatism, back, spine, bone, joint, muscle or rectal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Ulcer or disorder of the stomach. Intestines, hemorrhoids or rectal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Gall bladder stone or liver disease or any type of hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, tumor or growth of any kind of any organ system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Anemia, thyroid disorder (such as Goiter) or Rheumatic Fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- K. Sexually transmitted disease such as syphilis, gonorrhoea or non-specific arthritis?
- L. AIDS or AIDS-related conditions?
- M. Smoking/Chewing Tobacco?
If Yes, please specify. _____ per day.
If more than one person smokes please write in the respective order of the check marks.
- N. Any illness or injury not mentioned above?
- O. Any other form of Addiction?
If Yes, please specify.

4. If any of the answers is 'Yes' to questions in 2 & 3, please give details below and number your answers to correspond with the number of the questions to which the answer is applies.

Q No.:	Name of Person:		
Type of Disability:		Current Status:	Date of Disability: DD / MM / YYYY
Name & Address of Hospital/Clinic and Physician:			

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D. Further Personal Particulars:

Please fill in appropriate order of Proposer, Spouse and children for family insurance.

Blood Type:	<input type="text"/>
Usual Doctor/Physician of Choice:	<input type="text"/>
Address:	<input type="text"/>
Known Allergies:	<input type="text"/>

E. Insurance History:

- 5. Have you or your dependents 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: _____ _____ _____ _____ _____

F. Contact Information:

Contact Person:	<input type="text"/>	Contact Number:	<input type="text"/>
E-Mail:	<input type="text"/>		
Secondary Contact:	<input type="text"/>	Contact Number:	<input type="text"/>
E-Mail:	<input type="text"/>		

G. 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 limitations 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.

Signature: _____.

Date: DD / MM / YYYY

OFFICE USE ONLY	
Stamp & Signature:	Received By:
	Date: Time: