Allied Insurance Company
of the Maldives Pvt Ltd

Allied Insurance Company of the Maldives Pvt. Ltd.
#04-06 S.T.O. Trade Centre, Orchid Magu, Male', Republic of Maldives
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Corporate Group Health Insurance

Enrollment Form

The following items should be submitted with this form, Copy of ID card or Passport.

Employer Name ....

Policy Number ....

Applicant Status

☐ **Employee**

☐ **Dependent**

Employee Info (All applicants need to fill this section)

Employee Name ....

ID Card / Passport No. ....

Employee Number ....

Job Title ....

How many dependents are enrolled in this plan ....

Dependent Info (This Section has to be filled if applicant is a dependent)

Dependent Name ....

ID Card / Passport No. ....

Relationship with Employee ....

**** Each Dependent needs to fill out a separate form**

Date of Birth .... *dd/mm/yyyy*

Contact No. ....

Height .... *cm*

Weight .... *Kg*

Gender ....

Nationality ....

Address ....

Declaration (Please Tick ☑ The Appropriate Box)

Yes	*No*	
☐	☐	**1.** Do you 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,
☐	☐	**a)** Suffered or have any physical defects, infirmity or congenital conditions?
☐	☐	**b)** Been currently under observation or receiving treatment or taking any medications?
☐	☐	**c)** Undergone any surgical operation or suffered any disease or injury?
☐	☐	**d)** Ever been advised to have a surgical operation which has not been performed?

3. If any of the answers is **'YES'** to questions **'2'**, please give details below and number your questions to correspond with the number of the questions to which your answer applies;

Question No. & Details ....

....

Question No. & Details ....

....

Type of Disability ....

Diagnosed Date .... *dd/mm/yyyy*

Current Status of Disability ....

Name and Address of Hospital and Physician ....

....

Declaration By Proposer (To Be Read Carefully Before Signing)

I hereby declare that the above answers and statements are true, and that I have not withheld any information what so ever regarding this proposal. I agree that this Declaration and the information given above as well as any proposals or declaration or statement made in here by me or anyone acting on my behalf shall form the basis of the contract between me.

I here by further declare that I agree that in the event the declaration shall contain misstatement, misrepresentation, suppression and/or fraud, the issuance of the policy shall not be nor deemed to be a wavier of such misstatement, misrepresentation, suppression and/or fraud.

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

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

Signature ....

Date ....