

GROUP LIFE INSURANCE PROPOSAL FORM



Mr/Mrs/Ms: _____

Surname: _____

First Name(s): _____

Company: _____

Date of Birth: _____ Country of Birth: _____

Occupation (please give exact nature of duties)

Have you ever submitted a proposal for life or health insurance which has been subject to special terms, declined, postponed or withdrawn by this or any other company? If YES, give details below or enter NONE as appropriate.

Company _____ Country _____ Year of Proposal _____

Are you likely to

Engage in aviation other than as a fare paying-passenger on a commercial airline? Yes No

Reside or travel outside your country of residence other than on holiday? Yes No

Undertake any hazardous pursuit or pastime, such as diving, mountaineering, etc.? Yes No

Please give detail below: Y/N

Please provide name and address of your usual medical attendant below. If this contact has been your medical attendant for less than twelve months please also indicate name and address of previous attendant.

Please provide details of: Your height _____ Your weight _____

What is your daily habit regarding: Alcohol Tobacco

Are you currently receiving any treatment, medications, or on any special diet?

If YES, please give full details, including dates, durations, names and addresses of doctors attended in the table on the next page.

Have you ever received a medical diagnosis of any of the following conditions?

Please give full details below as appropriate.

- Rheumatic fever
- Heart or any circulatory trouble
- Raised blood pressure, whether subject to treatment or otherwise
- Raised cholesterol or blood lipids
- Diabetes Mellitus
- Asthma, bronchitis or other respiratory trouble
- Anxiety, depression or nervous trouble
- Tumour, growth or swelling of any kind
- Any other serious condition or ailment

Have you ever received (or expect to receive) any medical advice, counseling treatment, blood test or any other test in connection with AIDS, and AIDS-related condition, Hepatitis B or sexually transmitted disease?

During the last 5 years, have you been incapacitated from work for more than one week, suffered any serious illness or injury, consulted any medical adviser or attended hospital?

If YES, please give full details, including dates, durations, names and addresses of doctors attended in the table on the next page.

Have any of your immediate family members (parents, brothers, sisters) ever suffered from diabetes, stroke, cancer or heart disease? If YES, please state current age or age of death.

Additional details to questions answered YES

Question No. Date occurring Condition Treatment Duration

Declaration

I declare that to the best of my knowledge and belief the above statements are true and I agree that they shall be the basis of the assurance of my life under the above Scheme, I consent to _____ Insurance Company Limited seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health or seeking information from any insurance office to which a proposal has been made for insurance of my life and I authorise the giving of such information.

I understand that failure to disclose relevant information may invalidate any claim.

Signature of Proposer: _____ Date: _____