Proposal for Critical illness Insurance

Important: this proposal for insurance will be the basis of any subsequent insurance policy that we issue to you. It is essential that you answer fully and accurately all of the questions contained in this proposal, and that you provide us with any and all additional information relevant to the risk to be insured or our decision as to the acceptance of the risk or the terms upon which it should be accepted. Your failure to comply with this obligation now may result in the rejection of any claim and the avoidance of your policy when a claim is made. If you are in any doubt about the information to be given, please seek the advice and guidance of your insurance advisor or agent. If there is insufficient space in this proposal for you to provide relevant information, whether as requested or otherwise, please attach a separate sheet to this proposal and return it to us.

SECTION 1 APPLICANT IDENTIFICATION AND PROOF OF AGE

(Surname) (First Name)

Name Mr. / Ms.

Gender : Male ☐ Female ☐ Birth Date

Marital Status : Married / Single Divorced / Widowed

Please provide a copy of any of the following documents as proof of age (4 whichever is applicable)

Passport ☐ Municipal Birth Certificate ☐ Domicile Certificate ☐ School or College Certificate ☐

Address : (Leave one box between two words)

City: Code State: .

Res. Telephone : Work Telephone :

E - mail :.

Employer's Name and Address

Occupation and Title Years of employment at current Employer :

SECTION 2 INSURANCE INFORMATION

Critical Illness benefit applied for USD.

Do you have other current or pending critical illness Insurance with us? YES ☐ NO ☐

If yes Policy No.

Do you have other current or pending critical illness Insurance with another Company? YES ☐ NO ☐

If yes:

Name of Institution : Sum Insured: Year D D M M Y Y Y Y

Has any proposal for Life, Accident, Disability cover, Critical Illness or any other Health-Related Insurance on your life ever been postponed, declined or accepted on special terms? YES ☐ NO ☐

If yes, give details including amount applied for :

SECTION 3 HEALTH STATUS

PLEASE ANSWER ALL QUESTIONS BY CHECKING EITHER THE YES OR NO BOX

1. Are you now in good health and entirely free from any mental or physical impairments or deformities? YES ☐ NO ☐

2. Height _____ (Cm.) Weight _____ (Kg.)

How much weight have you lost or gained over the last 12 months? _____(Kg.)

Reason for weight change: _____

3. Have you ever suffered or do you now suffer from:

   a) Diseases of the circulatory system (e.g. heart trouble, chest pain, rheumatic fever, high blood pressure, diseases of the arteries and veins)? YES ☐ NO ☐

   b) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia or emphysema)? YES ☐ NO ☐

   c) Diseases of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)? YES ☐ NO ☐

   d) Diseases of the gastrointestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B, hepatitis C or other disorders of the liver, disorders of the gall bladder)? YES ☐ NO ☐

   e) Diseases of the nervous system or mental disorders (e.g. stroke, epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown, depression or other mental or psychiatric disorder)? YES ☐ NO ☐

   f) Diabetes mellitus, cancer or tumour of any kind, or any diseases of the blood, glands, spleen, ears, eyes or skin? YES ☐ NO ☐

   g) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands? YES ☐ NO ☐

   h) Any other diseases or ailments not mentioned above? _____

4. Have you or any of your immediate family members (father, mother, brother, or sister) have/had cancer, heart attack, or stroke and at what age? Prior to age 60? YES ☐ NO ☐

5. Have you ever had or been advised to have hospital treatment or surgery? YES ☐ NO ☐

6. Have you ever had or been advised to have a blood test for AIDS or an AIDS-related condition or have you ever been refused as a blood donor? YES ☐ NO ☐

7. In the past 5 years, have you consulted a physician for any reason or have you had any investigation such as blood or urine tests, X-rays, electrocardiograms, ultra sonograms, CT scans or biopsy, other than for routine employment or immigration purposes? YES ☐ NO ☐

8. Have you ever received or do you now receive any personal accident, disability benefit, or disability-related payments? YES ☐ NO ☐

9. Are you at present or any time in past were on any medication, special diet, or treatment? YES ☐ NO ☐

10. Have you ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption or the taking of drugs? YES ☐ NO ☐

11. Do you participate or do you intend to participate in any hazardous sports or activities such as motor sports, climbing, parachuting, hang-gliding, or aviation except as a fare-paying passenger? YES ☐ NO ☐

12. Are you pregnant (for female only)? If yes, please state how many months. Please state if you had any pregnancy related complication during your previous pregnancy/delivery? YES ☐ NO ☐

13. Have you smoked or used any substance or product containing tobacco, nicotine or marijuana? YES ☐ NO ☐

If yes, please state duration and average daily consumption and type: _____

14. Name and address of your regular medical consultant:

_____

_____

_____

If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians) on the reverse of this form and include your signature and the date.

SECTION 4 PERSONAL INFORMATION COLLECTION STATEMENT

The information you provide to us is collected to enable us to carry on insurance business and may be used for the purpose of (i) any insurance or financial related product or service or any alterations, variations, cancellation or renewal of them; (ii) any claim or analysis of it; and may be transferred to any related company or any other company carrying on insurance or reinsurance related business or any intermediary or claims investigator or other service provider providing services relevant to insurance business or any association or federation of insurance companies that exists or is formed from time to time.

You have the right to obtain access to and to request correction of any personal information concerning yourself held by Alliance Insurance. Requests for such access can be made to the Company.

SECTION 5 AGREEMENT

I hereby declare and warrant that the above statements are true and complete in all respects and that there is no other information which is relevant to my application for insurance for myself or any other person to be insured that has not been disclosed to you. I agree that this proposal and the declarations shall be the basis of the contract between me and Alliance Insurance and I agree to accept a policy, subject to the conditions prescribed by Alliance Insurance.

I hereby apply for Critical Illness Insurance under Individual Insurance Policy issued to me by Alliance Insurance, subject to all terms, conditions and provisions of the policy.

I understand that no insurance can be granted prior to approval by Alliance Insurance.

I understand that the insurance coverage will commence after the first premium is received by Alliance Insurance.

I authorize any physician, nurse, hospital official or employee to disclose to the Alliance Insurance any and all information regarding my medical history.

_____ _____/_____/_____

APPLICANT'S SIGNATURE DATE (Day/ Month/ Year)

If you answered "yes" to any of the questions numbered 1 to 13 (in Section 3 Health Status), please give complete details (including dates, duration and treatment, names and addresses of physicians)

Applicants Signature