Pragati Life Insurance Ltd

Trust us for Life

Head Office : Pragati Insurance Bhaban (Level-3), 20-21 Kawran Bazar, Dhaka-1215.
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HEALTH INSURANCE MEMBERSHIP APPLICATION FORM

(Please fill in capital letters and tick mark in appropriate boxes)

1 (One) Passport Size Photograph for each member

1. Name of Employer							
2. Name of Employee							
3. Current Address							
4. Designation					5. PF/ID No.		
6. Date of Birth	Day	Month	Year	7. Sex	Male	Female	

8. Marital Status : Married ☐ Unmarried ☐ Divorce/Others ☐ 9. No. of Children ☐

10. Dependents to be included under the Plan

Name	Date of Birth	Sex	Relationship

11. Coverage For : Self ☐ Spouse ☐ Family (Spouse & Children) ☐

12. Plan Option : Economy ☐ Executive ☐ Executive Plus ☐ Corporate ☐ Corporate Plus ☐

HEALTH QUESTIONSAIRE

No insurrance cover will apply in respect of any condition or related conditions, which exists or has existed before the acceptance of risk by Pragati Life Insurance Ltd. unless it has been declared to and accepted by Pragati Life Insurance Ltd. It is, therefore, in your interest, answer these questions fully and provide accurate information.

If the answer is "Yes", write details in the space provided below :

A. Currently are you or any of the dependents to be included in the plan.

(i) suffering from tubercelosis, diabetes, asthma, rheumatic fever, heart disease, hypertension, epilepsy, kidney disease, genito-urinary or gynecological disorder, cataract, cancer, mental illness, hernia, any disease of recurring nature or any chronic ailment? **Yes** ☐ **No** ☐

Name of person	Disease	Duration

(ii) receiving any treatement or on a special diet or on regular check up or have symptoms of any illness, injury, disability, impairment which is known, evident or suspected? **Yes** ☐ **No** ☐

Name of person	Details

(iIi) covered under any/health insurance policy from any insurance company for similar benefits? **Yes** ☐ **No** ☐

Name of person	Insurer	Benefit limit & date of commencement

Please Turn Over

B. Within the last five years, have you or any of the dependents to be included in the plan

(i) been incapacitated for a period of minimum 05 days due to injury, illness, disability, impairment or admitted to a hospital/clinic/sanatorium for treatment of operation? **Yes** ☐ **No** ☐

Name of person	Reason	Date	Current situation

(ii) consulted a specialist or attended a hospital/clinic as an out-patient for the purpose of operation, investigation or X-ray? ☐ ☐

Name of person	Reason	Date	Current situation

C. At any time, have you or any of the dependents to be included in the plan

(i) suffered from any illness, impairment, deformity or disability which still exists or recurring in nature or has left any residual effect or required surgical operation, care in ICU/CCU or long term treatment? ☐ ☐

Name of person	Reason	Period	Current situation

(ii) been postponed, declined, or accepted on special terms by any insurance company for a life or health insurance policy ? **Yes** ☐ **No** ☐

Name of person	Reason	Date	Type of insurance and date of coverage

D. Any married female to be include in the Plan

(i) is pregnant now? **Yes** ☐ **No** ☐

Name of person	Duration of Pregnancy	EDD (if known)

(ii) had complicating in any of her previous pregnancy or delivery? **Yes** ☐ **No** ☐

Name of person	Name of complication	Mode of delivery

E. Is there any additional information relating to the health of yourself or any of the dependents to be included in the plan which is not yet mentioned, e.g.a pre-existing condition or congenital anomaly? **Yes** ☐ **No** ☐

Name of person	Reason	Details	Current situation

13. DECLARATION

I declare that the information given in this application are true and complete to the best of my knowledge. It is agreed that declaration and information given in this application, together with any supplementary application, declarations or disclosures made by me shall form the basis of my/our insurance coverage. If after the insurance is effected, it is found that the information furnished in this form are incorrect or untrue, the company shall have the right to decline any claim relating to such information.

Signature (Plan Secretary) with date : ..... **Signature (Applicant) with date** .....

PLIL

Date of receipt :	Policy Number	Date of Commencement

Remarks :