

Policy Number
 Proposal Number

F. Is there any additional information relating to the health of yourself or any of the dependents to be included in the plan that you should disclose in good faith? Yes No

Name of person	Details

17. DECLARATION

- I declare and warrant that
- i. The statements made in this Proposal Form are true and complete to the best of knowledge and belief. This Proposal Form and Statements, together with supplementary information, declarations or disclosures made by me shall be the basis of the contract should the insurance be effected.
 - ii. If there is any alteration in above statements made by me under **health questionnaire** for my self or any of the dependant to be included under the plan before the date of issue of cover note, I shall immediately intimate the same to the company in writing.
 - iii. If after the insurance is effected it is found that the statement or particulars furnished in this form are incorrect or untrue, then the contract shall stand void and all the premium paid shall be forfeited to Delta Life & in such case the company shall have the right of recovery of any claim paid to me under this contract.

Signature of the Proposer Date

STATEMENT OF THE MARKETING OFFICER

The proposer is known to me since years and he leads a normal and healthy lifestyle. The age declared by him seems reasonable and in my opinion the proposal may be accepted by the company.

O. C.
 A. M.
 M. O.
 M. A.

Signature of the Marketing Officer Date

Underwriting Approval:



DELTA LIFE INSURANCE COMPANY LIMITED
DELTACARE HOSPITALIZATION PLAN
PROPOSAL FORM

(PLEASE USE BLOCK LETTERS)

1. Name of Proposer :
 2. Father's Name :
 3. Mailing Address :
 4. Telephone No. (if any) :
 5. Date of Birth : / /
 6. Age in yrs. on next Birthday
 7. Sex: Male Female
 8. Marital Status: Married unmarried
 9. Occupation :
 10. Nature of Work :
 11. Type of Cover: Mastercare Supercare Deluxecare Exclusivecare Royalcare
 12. Period of Coverage : 1 year 3 years
 13. Supplementary Coverage : Overseas Maternity
 14. Dependents to be included in the plan :

Name	Date of Birth	Sex	Relationship
i)
ii)
iii)
iv)

15. Particulars of Payment Total Amount Deposited Tk..
 Mode of Payment Cash / Draft / Cheque PR/BM No. Date : / /

For office use by Delta Life
 Date of Bank confirmation / / Date of Issue of Cover Note / /

Please note: -
 i. Attach 2 (Two) stamp sized photographs (2.5 cm X 2 cm) of each person/s applying for insurance.
 ii. Enclose age proof of the proposer and dependents to be included in the plan.

16. HEALTH QUESTIONNAIRE

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

Please (✓) in the appropriate box beside each question. If the answer is "Yes", give details in the space provided below. Use extra Paper (if needed)

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

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

Name of person	Reason	Period	Current situation
.....
.....

- (ii) consulted a specialist or attended a hospital/clinic as an out-patient for the purpose of operation, investigation or X-ray ? **Yes** **No**

Name of person	Reason	Date	Current situation
.....
.....

B. Currently are you or any of the dependent to be included in the plan

- (i) suffering from tuberculosis, diabetes, asthma, rheumatic fever, heart disease, hypertension, epilepsy, kidney disease, cancer, mental illness, hernia, any disease of recurring nature or any chronic illness ? **Yes** **No**

Name of person	Disease	Duration
.....
.....

- (ii) receiving any treatment or medication, or on a special diet or on regular checkup or have symptom of any illness, injury, disability, deformity, impairment which are known, evident, or suspected ? **Yes** **No**

Name of person	Details
.....
.....

C. Have you or any of the dependent to be included in the plan

- (i) at any time, suffered from any illness, impairment, deformity or disability which still exists or recurring in nature or has left any residual effect or required major surgery, care in ICU/CCU or long term treatment? **Yes** **No**

Name of person	Reason	Period	Current situation
.....
.....

- (ii) is at present covered under any health insurance policy from any insurance company for similar benefits ? **Yes** **No**

Name of person	Insurer	Benefit limit & date of Commencement
.....
.....

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

Name of person	Insurer	Policy Details	Reasons
.....
.....

D. Any married female to be included in the plan

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

Name of person	Duration of Pregnancy	EDD (If known)
.....
.....

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

Name of person	Nature of Complication	Mode of Delivery
.....
.....

E. Have you or any of the dependents to be included in the plan is habituated to smoking, alcohol or drugs?

- Yes** **No**

Name of person	Details
.....
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