



# Delta Life Insurance Company Limited

Central Office : Uttara Bank Bhaban, 90-91, Motijheel C/A, Dhaka-1000, Bangladesh

PABX : 9565033-(Auto hunting) Fax : 880-2-9562219, E-mail : [deltanet@citechco.net](mailto:deltanet@citechco.net)

## PROPOSAL FORM FOR OVERSEAS MEDICLAIM POLICY-(B & H)

*(To be submitted in original with two copies)*

*( Available to persons in the age group of 6 months to65 years)*

THE OVERSEAS MEDICLAIM POLICY PROVIDES INDEMNITY FOR EXPENSES INCURRED FOR MEDICAL TREATMENT FOR ILLNESS, DISEASES CONTRACTED OR INJURY SUSTAINED DURING OVERSEAS TRAVEL AND WHICH IS PRIMARILY IN THE NATURE OF AN EMERGENCY AND WHICH IS NECESSARY TO BE UNDERTAKEN IMMEDIATELY, WITHOUT WHICH THE PROPOSER IS NOT ABLE TO LEAVE THE OVERSEAS COUNTRY UNDER MEDICAL ADVICE. THE ATTENTION OF THE PROPOSER IS DRAWN TO ITEM II (MEDICAL HISTORY) OF THE PROPOSAL FORM, ESPECIALLY IN RELATION TO PREVIOUS TREATMENT OF ILLNESS OR DISEASES SUCH AS RENAL DISORDERS OR DISEASES, CEREBRAL OR VASCULAR STROKES, HEART AILMENTS OF ANY KIND, MALIGNANCY, T. B, ENCEPHALITIS, NEUROLOGICAL DISORDERS, GALL BLADDER DISORDERS, ARTHRITIS REQUIRING SURGERY AND IF ANY TREATMENT HAS BEEN RECEIVED FOR ANY OF THE ABOVE DISORDERS AT ANY TIME IN THE PAST. SUCH TREATMENT MUST BE DISCLOSED TO THE ISSUING OFFICE.

THE PROPOSAL FORM SHOULD BE COMPLETED TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, AND ALL MATERIAL FACTS\* SHOULD BE DISCLOSED. FAILURE TO DO SO MAY NULLIFY COVER UNDER ANY POLICY ISSUED.

\*A material fact is one that is likely to influence the insurer's acceptance or assessment of the proposal. You should consult Delta Life Insurance Co. Ltd. if you are in any doubt as to what constitutes a material fact.

- I.1. Name of the proposer (In block letters) :  
as stated in the passport  
State whether Mr./Mrs./Miss/Master
2. Home address :
3. Home Telephone No. (if any) :
4. Proposer's Actual Occupation (specify) :
5. Office Name and address :
6. Office Telephone No. :
7. Date of Birth (as on Passport) :
8. Passport Number :
9. Plan Type : Worldwide (excluding USA & Canada)  
Plan - A   
Worldwide (including USA & Canada)  
Plan - B
10. Purpose of Trip (State official/  
holiday travel in conducted tour/  
holiday travel individual) :
11. Proposed date of departure from the  
People's Republic of Bangladesh :
12. Number of days stay outside the People's  
Republic of Bangladesh  
(Please note that no extension can be granted) :
13. Itinerary (State countries and places to  
be visited and approximate number of  
days at each place) :
14. Name and address of the usual  
physician and registration No. :  
  
Telephone No. Consulting Room/Office :  
Residence :

**II. A. MEDICAL HISTORY (TO BE COMPLETED BY THE PROPOSER)**

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES OR NO (A DASH IS NOT SUFFICIENT AND GIVE FULL DETAILS)

1. Are you in good health and free from physical and mental disease or infirmity? : \_\_\_\_\_
2. Have you ever suffered from
  - (a) any nervous, mental or psychiatric disease, slipped disc or other spinal disorder, fainting episode, blackout, fit or paralysis of any kind? : \_\_\_\_\_
  - (b) high blood pressure, heart diseases including ischaemic heart disease, piles, varicose veins, other circulatory disorders or rheumatic fever? : \_\_\_\_\_
  - (c) hernia, any rheumatic or joint disease, urinary disease or diabetes? : \_\_\_\_\_
  - (d) any respiratory or allergic disease, or any disorder of the stomach, bowel or gall bladder? : \_\_\_\_\_
  - (e) any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations? : \_\_\_\_\_
  - (f) any complaint or tendency that may necessitate such consultation or treatment in the future? : \_\_\_\_\_
3. Are there any additional facts affecting the proposed insurance which should be disclosed to insurers? : \_\_\_\_\_
4. Have you any intention of engaging in winter sports or pastimes rendering you liable to personal injury? : \_\_\_\_\_
5. Give particulars of any other illness or disease or accident sustained by you during the 12 months preceding the first day of Insurance in the table below. : \_\_\_\_\_

Nature of illness/disease/injury and treatment received	Date first treated	Name of attending medical practitioner/surgeon with his address and Telephone Number
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- 1.
- 2.
- 3.
- 4.
6. Please give details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention whilst on tour abroad.
  - 1.
  - 2.
  - 3.
  - 4.

**II. B. TO BE COMPLETED BY THE DOCTOR**

- (1) a) History :
  - b) Any past history of disease, operation, accident, investigations etc. :
  - c) General Examination :
  - d) Systematic Examination :
  
- (2) Electrocardiography :
  - a) Does the attached Electrocardiogram in your professional opinion show any abnormalities and if so, please describe :
    - b) Does the abnormality represent a current illness or disease which may possibly be expected to require medical treatment during proposer's forthcoming trip? :
    - c) Does the proposer now or did he/she in the past, require medication for this abnormality? :
    - d) Please describe any treatment taken by proposer in the past or being taken at present. :
    - e) Do you consider that proposer is fit to travel anywhere abroad, due account being taken of the stress of air travel adversely affecting his/her medical condition ? :
  
- (3) Does the Urine Strip Test show any sugar?

Signature of the Doctor :

Name of the Doctor :

Qualifications

Address :

Telephone No.

