OVERSEAS TRAVEL INSURANCE PLAN – STUDENT CARE

PROPOSAL FORM

Policy No: ☐ (To be filled by ORIENT Insurance)

Insurance Plan Requested: ☐ Plan A ☐ Plan B ☐ Ultimate

Category Incl. USA/Canada: ……………………………… Excl.USA/Canada: ………………………. ………..

Destination: ……..

Departure Date: _ _ / _ _ / _ _ (DD MM YY) Return Date: _ _ / _ _ / _ _ (DD MM YY) Number of days: …………………………… (Departure & Return, both days inclusive)

Name of person to be insured: Mr / Mrs / Ms : ………………………………………………………………………………

……..

Permanent Address: ………...

……… … …………………..

Contact Telephone Number: Sri Lanka: ………………………… While Overseas: ………………………………………

E-Mail ID : …….

Passport Number: ……………………………… N I C No : ……………………………………………

☐ Male ☐ Female Date of Birth: _ _ / _ _ / _ _ (D D M M Y Y)

Name of the Organization:……………………………………………………………………………………………………

Beneficiary: ……………………………………….. Relationship: ……………………………………………..

Additional family members to be insured (Spouse or dependent children)

	Name	Sex	Date of Birth	Passport No.	Beneficiary Name	Relationship
1		M/F				
2		M/F				
3		M/F				
4		M/F				

MEDICAL DECLARATION

1. Have you received any advice / treatment / consultation for any medical condition in the last 5 years?

☐ Yes ☐ No

If yes, please specify details of Treatment, Institution and Doctor (Identify per family member)

Member	Treatment	Institution	Doctor
You			
01.			
02.			
03.			

2. I am/we are presently taking specific prescription medication.

☐ Yes ☐ No

If yes, please name the prescribed medication you are taking (Identify per family member)

	You	Member 1	Member 2	Member 3
Prescribed Medication				
Time (since)				

3. I am/We are covered under a domestic and overseas medical cover.

☐ Yes ☐ No

If yes, please specify name, address and policy number of the insurance company.

Name	Policy No.	Insurance Company	Address

4. Do you give your consent to use your personal information for future marketing activities or Cross selling activities (If any)

☐ Yes ☐ No

The policy excludes pre-existing medical conditions that are declared and undeclared.

* In the event of a claim, in order to determine eligibility for benefit payments under the policy, I/We authorize any medical care institution, physician, medical professional, pharmacy or insurers to furnish Orient Insurance Company Ltd., or its representatives any and all medical information or records with respect to any injury or sickness suffered by the person whose death, injury, sickness or loss is the basis of a claim against the policy. * I/We understand that this authorization is valid during the pendency of the claim until all issues with regard thereto have been definitively resolved, either extra-judicially or judicially. * I/We hereby declare and warrant that all of the statements above are true and complete. If it is found that the answers or particulars stated in this Proposal Form and Medical Declaration are incorrect or untrue in any respect, I/We hereby acknowledge that ORIENT Insurance Company shall not incur liability for any insurance coverage.

LIABILITY OF ORIENT INSURANCE LIMITED DOES NOT COMMENCE UNTIL THE PROPOSAL IS ACCEPTED AND COVER CONFIRMED IN WRITING.

…….. Date: _ _ / _ _ / _ _ _ _

Signature of the Proposer DD MM YYYY

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