1. PROPOSER DETAILS

Proposer (Mr./Ms./Mrs.) - Name in full																									
Address																									
Contact No	Mobile																								
	Home																								
	Office																								
	E-mail																								
NIC/Passport No														Date of Birth											
Gender	M			F										Age											
Nationality														Marital status											
Height (cm)														Weight (kgs)											
Occupation																									
Name & the address of the employer :																									

2. PLAN DETAILS

Plan	1		2		3		4		5		6		Type	Individual				Floater							
Proposed Policy Period															TO										

3. EXISTING/PREVIOUS INSURANCE DETAILS

Is the proposer or the persons proposed, already insured under a plan with any other insurance company. If yes,

Yes		No	

Policy No	Insurer	Period of insurance	Sum insured	Claims

4. MEDICAL AND LIFE STYLE INFORMATION

Section A : Is proposer to be insured ever suffered from/ are currently suffering from any of the following.

i. Hypertension, Chest Pain, Ischemic heart disease or any other cardiac disorder	Yes		No	
ii. Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	Yes		No	
iii. Ulcer (stomach/duodenal), hepatitis, cirrhosis or any other Digestive or Liver/ Gallbladder disorder	Yes		No	
iv. Renal failure, calculus or any other Kidney/Urinary tract or Prostate disorder	Yes		No	
v. Dizziness, Stroke, Epilepsy, Paralysis or other brain/ nervous system disorder	Yes		No	
vi. Diabetes, Thyroid disorder or any other endocrine disorder	Yes		No	
vii. Tumor-benign or malignant, any ulcer/growth/cyst	Yes		No	
viii. Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	Yes		No	
ix. Diseases of the Nose/Ear/Throat/Teeth/ Eye (please mention Diopters)	Yes		No	
x. HIV/AIDS or sexually transmitted diseases or any immune system disorder	Yes		No	
xi. Anaemia, Leukaemia or any other blood/lymphatic system disorder	Yes		No	
xii. Psychiatric/Mental illnesses or Sleep disorder	Yes		No	
xiii. DUB, Fibroid, Cyst/Fibroadenoma or any other Gynaecological/Breast disorder	Yes		No	
xiv. Hernia, Hydrocele, Piles	Yes		No	

Section B : Is proposer to be insured:

i. Been addicted to alcohol, narcotics, habit forming drugs or been under detoxication detoxication therapy?	Yes		No	
ii. Been under any regular medication (self/ prescribed)?	Yes		No	
iii. Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	Yes		No	
iv. Undertaken any surgery or a surgery been advised in the last 10 years or is a surgery still pending?	Yes		No	
v. Suffered from any other disease/illness/accident/injury other than common cold or fever?	Yes		No	
vi. Is any of the insured persons pregnant? If yes, please mention the expected date of delivery _____	Yes		No	
vii. Any complaint of diabetes, hypertension or any complication during current or earlier pregnancy?	Yes		No	

viii. Where was a doctor last consulted and for what complaint _____

_____

Section C : Name and details of Illness/ Medicine/Test/Surgery/Diopter grade

(for questions answered as Yes in Section A & B above)

Name and details of illness / medicine / test / surgery / diopter grade	Dignosis date	Date of last consultation	Treatment IN / Out patient	Doctor / Hospital name & phone no

Section D : In respect of any of the persons proposed to be insured:

Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, postponed, loaded or been made subject to any special conditions by any insurance company?

Yes		No	

if "Yes"

Policy No	Insurer	Period of insurance	Sum insured	Claims

Section E : Hobbies & pastimes:

Have you ever participated in (or anticipate doing so) any hazardous sport or activity?

Yes		No	

Note: examples of hazardous sports or activities include deep sea diving, hang gliding, horse racing, motor cycle racing, motor racing, steeple-chasing, mountaineering or any other sport as a professional. Flying except as an ordinary fare paying passenger on a regular public air service or charter plane.

If "Yes", give details

Section F : Name, address, qualification and contact details of the family doctor, if any:

Proposer (Mr./Ms./Mrs.) - Name in full	
Address	
Contact No	Mobile
	Home
	Office
	E-mail

DECLARATION

I DECLARE that the statements made in this proposal are true in every respect and that I have not withheld any information requested therein or any other information of a material nature and that these statements and this declaration and any statement made by me to the medical examiner shall form the basis upon which Orient Insurance Ltd, would insure my life and that if any untrue averment/statements be contained herein the said assurance on my life shall be of no force or effect.

I CONSENT to allow Orient Insurance Ltd to seek from any doctor, clinic or hospital any medical information concerning anything which affects the physical or mental health of myself or seeking information from and other insurer to whom a proposal has been made for life assurance on my life and I authorize the giving and receiving of such information. I AGREE to inform Orient Insurance Ltd of any changes in the health or occupation of myself between the date of this proposal and the date of acceptance.

Dated at …….. On this ……day of ……year two thousand

Signature of Life Assured (applicant)

NOTE TO BE:

Above 45 years;

In case if the proposer fail the medical test, full premium will be returned subject to deducting an administrative fee of LKR 1,500/-

Below 45 years;

In case of the proposer is requested by the insurer to undertake a medical test, all cost pertaining to the same should be borne by the proposer.

Below 18 years; Should be accompanied with guardian