

Corporate Group Health Insurance

Enrollment Form

The following items should be submitted with this form, Copy of ID card or Passport.

Employer Name	Policy Number
Applicant Status	
<input type="checkbox"/> Employee	<input type="checkbox"/> Dependent
Employee Info (All applicants need to fill this section)	Dependent Info (This Section has to be filled if applicant is a dependent)
Employee Name	Dependent Name
ID Card / Passport No.	ID Card / Passport No.
Employee Number	Relationship with Employee
Job Title	
How many dependents are enrolled in this plan	
** Each Dependent needs to fill out a separate form	
Height <small>cm</small>	Date of Birth <small>dd/mm/yyyy</small>
Weight <small>Kg</small>	Contact No.
Gender	Nationality
	Address

Declaration (Please Tick The Appropriate Box)

<small>Yes</small>	<small>No</small>	
<input type="checkbox"/>	<input type="checkbox"/>	1. Do you have Health Insurance with us or any other company? If 'Yes', please attach a copy of the existing Policy Schedule.
<small>Yes</small>	<small>No</small>	
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you,
<input type="checkbox"/>	<input type="checkbox"/>	a) Suffered or have any physical defects, infirmity or congenital conditions?
<input type="checkbox"/>	<input type="checkbox"/>	b) Been currently under observation or receiving treatment or taking any medications?
<input type="checkbox"/>	<input type="checkbox"/>	c) Undergone any surgical operation or suffered any disease or injury?
<input type="checkbox"/>	<input type="checkbox"/>	d) Ever been advised to have a surgical operation which has not been performed?

3. If any of the answers is 'YES' to questions '2', please give details below and number your questions to correspond with the number of the questions to which your answer applies;

Question No. & Details
Question No. & Details
Type of Disability	Diagnosed Date <small>dd/mm/yyyy</small>
Current Status of Disability
Name and Address of Hospital and Physician

Declaration By Proposer (To Be Read Carefully Before Signing)

I hereby declare that the above answers and statements are true, and that I have not withheld any information what so ever regarding this proposal. I agree that this Declaration and the information given above as well as any proposals or declaration or statement made in here by me or anyone acting on my behalf shall form the basis of the contract between me.

I here by further declare that I agree that in the event the declaration shall contain misstatement, misrepresentation, suppression and/or fraud, the issuance of the policy shall not be nor deemed to be a wavier of such misstatement, misrepresentation, suppression and/or fraud.

I hereby authorize any hospital, surgeon, medical practitioner or clinic or other person who attended to me for any reason to disclose to the Insurance Company and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certifications, included any earlier medical history. A photocopy of this authorization shall be considered as effective and valid as the original.

I acknowledge that the liability of the Insurance Company does not commence until this proposal is accepted by and premium paid to the Insurance Company.

Signature **Date**