

Office

ॐ॥तन्नुगक्ताः हेत्रसूरः यथा वहेत् कर्।

ROYAL INSURANCE CORPORATION OF BHUTAN LTD.

Proposal #

SE/DO/Branch Code

"Your partner for growth and security"

Sales Executive Name

PROPOSAL FORM FOR MILLENNIUM EDUCATION SCHEME-III

(Answers must be given truthfully for the contract to be valid. Strokes, dots, and dashes will not be accepted as answers)

| D 11 M | 1: | Proposer's de | taiis | | |
|---|--|--|---|---|--|
| Full Name of Proposer | | | - | | |
| Citizenship ID Card # | | | | Mailing A | ddress |
| Present Occupation | | | | | |
| Nature of Duties | | | | | |
| Present Employer | | | | | |
| Previous Employer | | | | | |
| Fathers Name | | | | | |
| Mobile # | | | | Permanent | Address |
| Email Address | | | Village | | |
| Date of Birth | I I | Age | Gewog | | |
| Nature of Age Proof | | ı | Dzongkhag | 5 | |
| Bank Name | | | Height | | |
| Savings Account Number | | | Weight | | |
| | 2 | . Child's Deta | ails | | |
| Full Name of the child | | | | | |
| Date of Birth of the Child | | Father's N | lame of the | | |
| Age Proof of the Child | | Child | | | |
| Age of the Child | | Proposer's | s Relationship | with the Chile | d |
| | | | | | |
| | | | | | |
| m 11 /m | | olicy Property | | | 4 672 14 |
| Table/Term | 3. Po | | Details Mode | An | nount of Deposit |
| Table/Term What is the objective of Assi | Sum Assured | | | An | nount of Deposit |
| What is the objective of Assı State whether you wish to s | Sum Assured urance? ecure Premium Waiver | Benefit | | An | nount of Deposit |
| What is the objective of Assi | Sum Assured urance? ecure Premium Waiver | Benefit | | An | nount of Deposit |
| What is the objective of Assı State whether you wish to s | Sum Assured urance? ecure Premium Waiver secure Term Rider Bene | Benefit efit | Mode | An | nount of Deposit |
| What is the objective of Assi State whether you wish to s State Whether you wish to s | Sum Assured urance? ecure Premium Waiver secure Term Rider Bend | Benefit efit (a) Nominees D | Mode etails | | |
| What is the objective of Assı State whether you wish to s | Sum Assured urance? ecure Premium Waiver secure Term Rider Bene 4. minate a person whom | Benefit efit (a) Nominees D the money secu | Mode etails | | |
| What is the objective of Assi State whether you wish to s State Whether you wish to s If the proposer wishes to no | Sum Assured urance? ecure Premium Waiver secure Term Rider Bene 4. minate a person whom | Benefit efit (a) Nominees D the money secuminees. | Mode etails ared by the pol | | |
| What is the objective of Assi State whether you wish to s State Whether you wish to s If the proposer wishes to no the event of death. Please st | Sum Assured urance? ecure Premium Waiver secure Term Rider Bene 4. minate a person whom sate full name of the non | Benefit efit (a) Nominees D the money secuminees. | Mode etails ared by the pol | icy applied for | r are to be paid in |
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| What is the objective of Assi State whether you wish to s State Whether you wish to s If the proposer wishes to no the event of death. Please st | sum Assured urance? ecure Premium Waiver secure Term Rider Bene 4. minate a person whom rate full name of the nor Citizenship ID | Benefit efit (a) Nominees D the money secuminees. # Relations | Mode etails tred by the policible ship Age | icy applied for | r are to be paid in |
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| What is the objective of Assistate whether you wish to so State Whether you wish to so If the proposer wishes to not the event of death. Please state of Nominee Please state the name of the arising during the minority appointment. | Sum Assured urance? ecure Premium Waiver secure Term Rider Bend 4. minate a person whom tate full name of the not Citizenship ID (b) If the person whom you wish y of the nominee. The | Benefit efit (a) Nominees D the money secuminees. # Relations e Nominee is n to appoint to n appointee mu | minor receive the polest sign below | icy applied for % of Share | Address The event of the claim /her consent to the |
| What is the objective of Assi State whether you wish to s State Whether you wish to s If the proposer wishes to no the event of death. Please st Name of Nominee Please state the name of the arising during the minority | sum Assured urance? ecure Premium Waiver secure Term Rider Bend 4. minate a person whom tate full name of the nor Citizenship ID (b) If the person whom you wish | Benefit efit (a) Nominees D the money secuminees. # Relations e Nominee is n to appoint to n appointee mu | minor receive the polest sign below | icy applied for % of Share icy money in t | r are to be paid in Address The event of the claim |
| What is the objective of Assistate whether you wish to so State Whether you wish to so If the proposer wishes to not the event of death. Please state of Nominee Please state the name of the arising during the minority appointment. | Sum Assured urance? ecure Premium Waiver secure Term Rider Bend 4. minate a person whom tate full name of the not Citizenship ID (b) If the person whom you wish y of the nominee. The | Benefit efit (a) Nominees D the money secuminees. # Relations e Nominee is n to appoint to n appointee mu | minor receive the polest sign below | icy applied for % of Share | Address The event of the claim /her consent to the |

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| 5. If employed in the Armed Forced (RBP,RBG,RBA & Private Security) please state | | | | | | |
|--|---------------------------|--|--------------|----------------------------------|-----------------|-------------------|
| To which wing you belong | Your Rank | Date of your Las Medical Examination | st You | Your Medical Category Thereafter | | below A- when? |
| | | | | | | |
| Have you any prospect | t or intention of engagin | g in Aviation or ent | ering Naval | or Military Serv | rices or taking | g up any |
| other hazardous pursu | uit? If so give details | | J | · · | · | |
| | 6. State below the | details of your (P | roposer's) p | revious polici | es | |
| D 1: " | Insuring | G A 1 | D 1 | Year of | AB | Policy |
| Policy # | Agency | Sum Assured | Products | Issuance | Covered? | Status |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| | 7. Family History of the Proposer | | | | | | | |
|--------|-----------------------------------|-------|-----------------------|------------------|-----------------|----------------|---------------------|--|
| | LIVING | | | | DEAD | | | |
| Family | No. | Age | State of Health | Year of Death | Age at Death | Cause of Death | Duration of illness | |
| Fath | er | | | | | | | |
| Moth | er | | | | | | | |
| | Bro | thers | | | | | | |
| Living | | | | | | | | |
| Dead | | | | | | | | |
| | Sis | sters | | | | | | |
| Living | | | | | | | | |
| Dead | | | | | | | | |
| Spouse | | | | | | | | |
| | Chi | ldren | | | | | | |
| Living | | | | | | | | |
| Dead | | | | | | | | |

| | 8. Personal His | story of the Proposer | | | |
|--|--|---|-----|------|--|
| What h | nas been your usual state of health? | | | | |
| Have y | ou any defect or deformity? If so give details. | | | | |
| State r | number of missing teeth | | | | |
| For ho | w many missing teeth denture is worn. | | | | |
| 9. Medical questionnaires (Please tick) | | | | | |
| a. | Has any of your relations living or dead suffered f | from any hereditary disease like diabetics, | Yes | No | |
| | insanity, asthma, cancer, leprosy, etc | | 168 | NO | |
| b. | Persistent cough, asthma, bronchitis, pneumonia | , pleurisy, spitting of blood tuberculosis or | Yes | No | |
| any diseases of lungs? | | | | NO | |
| c. High or low blood pressure. Rheumatic, fever, pains in chest, number of attacks, dates, | | | Yes | N. | |
| breathlessness, palpitation, infection or any other diseases of the heart or arteries? | | | | No | |
| d. | Peptic ulcer, colitis, jaundice, piles, dysentery or a | any disease of stomach, liver, spleen, gall | 37 | NT - | |
| | bladder or pancreas? | | Yes | No | |
| e. | Any disease of kidney, prostate or urinary system | 13 | Yes | No | |
| f. | Paralysis, insanity, epilepsy, fits or any kind of ne | ervous breakdown or any other diseases of | 3.7 | 2.7 | |
| | the brain or the nervous system? | Ů | Yes | No | |
| g. | Hernia, hydrocele, varicocele, fistula, varicose vei | ns, skin eruption, filariasis, goiter, | | | |
| | gonorrhea, syphilis or any other Venereal disease | _ | Yes | No | |
| h. | Cancer, leprosy, rheumatism, gout, enlarged glan | | Yes | No | |
| i. | Any disease of the ear, nose, throat or eye includi | | | | |
| | discharge from the ears? | | Yes | No | |
| | | | 1 1 | | |

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<u>्ञापर्चित्रम</u>िण.केष.सीट.जरायहूष.क्री

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| j. | Have you been suspected of diabetes or are you suffering from diabetes or have ever passed sugar, albumin, pus or blood in urine? | Yes | No |
|----|---|-----|----|
| k. | | Yes | No |
| 1. | Have you ever had an Electrocardiogram (ECG), X-Ray or screening of blood, urine or stool examination? | Yes | No |
| m. | Do you or have you ever used alcoholic drinks, narcotics or any other drugs? If so, what? Also state quantity consumed per day. | Yes | No |

If "Yes" describes fully each ailment giving its nature, the number of attacks, dates, duration, severity, treatment of doctors consulted giving reference to the questions \dots details of Question #.

| 10. Income Details | | | | |
|--------------------------------------|--|-----------------------------|-----|----|
| Your Education Qualification, If any | | Your Monthly Average income | | |
| State Source of Income | | Are you paying Income Tax? | Yes | No |

| | 11. A | dditio | nal ques | stions for | FEMAL | E pro | poser | | | |
|---|-----------|--|----------|------------|-------------|---------|-------------|----------|-----|-----|
| Married Yes No If yes | | If yes p | lease do | fill up | husband's d | details | | | | |
| Husband's Name | | | • | | | | | | | |
| His Occupation | | | | | | | | | | |
| His average monthly income | | | | | | | | | | |
| Does your husband have any Li | fe insura | nce po | licies? | | Yes | No | If yes give | details | | |
| Policy # | Insur | | Sum A | Assured | Produc | cts | Year of | AB | | icy |
| | Agen | .cy | | | | | Issuance | Covered? | Sta | tus |
| | | | | | | | | | | , |
| State the last date of menstruation | | Did you have any complications related to pregnancy? | | Yes | No | | | | | |
| State the last date of delivery | | Are you Pregnant now Yes | | | | No | | | | |
| Have you suffered or are you suffering from any diseases of breast, ovaries or uterus | | | | | | Yes | No | | | |

DECLARATION BY THE PROPOSER

| Srl # | Question | YES | NO | | |
|-------|--|-----|----|--|--|
| 1 | Do you want to receive SMS on this? | | | | |
| | If the answer is YES, Please provide Mobile # | | | | |
| 2 | 2 Do you want to receive e-mail on this? | | | | |
| | If the answer is YES, Please provide e-mail address# | | | | |

Proposer's Signature

Notwithstanding the provision of any law, usage, custom or convention for the time being in force prohibiting any doctor, hospital, and/or employer from divulging any knowledge or information about me concerning my health or employment on any kind whatsoever in the policy contract issued to me, I hereby agree, that such authority having such knowledge or information, shall at any time be at liberty to divulge any such knowledge to the Corporation.

And I further agree and declare that I after the date of submission of the proposal but before the issue of the Policy Document:

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<u>्ञ्शायचैवामिल.केष.स्टरज्ञयसह</u>्ष्य.क्र्या

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- I. If there is any change in my occupation or any adverse cirsumstances connected with financial position or general health of myself or that any member of my family occurs; or
- II. If proposal for assurance or an application for revival of a policy on my life made to any Office of the Corporation has been withdrawn or dropped, deferred or declined, or accepted with an increased premium or subject to the lien or on terms other than as proposed;

I shall forthwith intimate the same to the Corporation in writing to reconsider the terms of acceptance of assurance. Any omission on my part to do shall render this assurance and all money, which shall have been paid in respect thereof, shall stand forfeited to the Corporation.

| Signature of Witness | |
|-------------------------|--|
| Name | |
| Mobile # | Signature or thumb impression of the |
| Address | proposer |
| CID # | (If it is a thumb impression, it has to be attested) |

If in this form the answers to the questions and/or signature of the proposer are/is in vernacular then he should declare in his own handwriting above his signature(s) that all questions were explained to him and that his responses to the questions were given after fully and properly understanding the same.

1) If the person filling in the form is other than the proposer, such person should make this declaration.

2)

I hereby declare that I have fully explained the above questions to the Proposer and I have truthfully recorded the answers given by the Proposer

| Name and Address of the declarant | |
|-----------------------------------|--|
| Signature | |

3) In case the Proposer is illiterate

The thumb impression of the proposer should be attested by person of a social standing whose identity can easily be established, but unconnected with the Corporation and the same person must execute the following declaration:

| Name and Address of the declarant | |
|-----------------------------------|--|
| Signature | |

| For Medical Cases only | | | | |
|---|--|--|--|--|
| I certify that the proposer has signed/caused his/her | thumb impression in my presence after admitting that | | | |
| all the answer to the questions of this form has been correctly recorded. | | | | |
| | | | | |
| | | | | |
| | | | | |
| Signature or thumb impression of the Proposer | Signature of Medical Examiner | | | |

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