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ROYAL INSURANCE CORPORATION OF BHUTANLTD.

R I C B

"Your partner for growth and security"

PROPOSAL FORM FOR HEALTH INSURANCE (INDIVIDUAL)

Agent details (To be filled in BLOCK LETTERS)

Corporate Agent Name		Code	
Sales Executive Name		Code	
Branch Name		Code	

Note - The Company will not be on risk until the proposal has been accepted and full payment of the premium made. Persons who are to be insured under the policy may have to undergo Medical examinations prior to the acceptance of the proposal as per company guidelines. The liability of Royal Insurance Corporation of Bhutan Ltd. commences only upon the acceptance of this proposal notwithstanding the payment of any deposit. Please fill up the form in BLOCK letters. Please submit two stamp sized photographs of the Person to be insured & the Proposer (if other than the person to be insured) for issuance of identity cards. If you are in any doubt about the information to be given, please seek the advice and guidance from your insurance advisor or agent.

Proposer's/Insured's details

Proposal Number			Policy Number		
Full Name of proposer					
Citizenship ID Card No					
Full Name of Insured (if different from proposer)					
Citizenship ID Card No of Insured					
Address (Mailing)					
Address (Permanent)					
Phone #			Mobile #		
Email ID			Fax #		
Nationality			Father's Name		
Name of Employer			Monthly Income		
Occupation			Nature of Duties		
Date of Birth			Age proof document submitted	Yes/No	
Education Qualification			Sum Assured		
Period of Insurance	From Date:			To Date:	

***Previous Insurance details (Proposer/Insured)**

Have you proposed under any other medical insurance policies or any other such scheme? If Yes, details thereof

Sr. No.	Name of the person	Relation to Proposer	Policy No	Insurer	Period of coverage		Sum Assured
					From	To	

1							
2							
3							
4							
5							

*Kindly attach separate sheet if required to furnish complete details.

Medical history for person to be insured (proposed)

Height in Centimeters		Weight in Kilograms	

1. Kindly provide the following information (Yes/No)	Yes / No
2. Are you in good health and free from physical or mental disease or infirmity or medical complaints? If not give full details	
3. Any proposal for medical insurance refused, cancelled or high premium charged by any insurer? If answer is yes please separate sheet and furnish details	
4. Have any claim been rejected by the previous health insurer, if Yes, please provide details	
5. Medical history and other details of the insured person (These details are not only required to underwrite the proposal form but also to render medical advice as may deem fit)(Please answer Yes or No) Have you suffered from any of the diseases/illness? If yes, give details	
a. Diabetes Mellitus	
b. High Blood pressure, Heart disease including Ischemic heart disease(IHD)/ Rheumatic heart disease	
c. Stroke, epilepsy, fainting attacks, chronic headaches	
d. Tuberculosis, Asthma, Respiratory allergic disorders	
e. Any diseases of bones/joints	
f. Cancer, malignant tumor, malignant growth	
g. Gynecological disorder such as dysfunctional uterine bleeding(DUB)/fibroid uterus/ovarian cyst	
h. Disease of stomach, liver & gall bladder	
i. Kidney diseases including kidney failure & renal stone	
j. Disease of the urinary bladder & prostate	
k. Fistula, piles, hernia, varicose veins	
l. Any dimness of vision, cataract	
m. History of tonsillitis or any other disease or disorder of the ear, nose or throat	
n. Any dental problems?	
o. Slipped disc, other spinal disorders or paralysis of any kind	
p. Any nervous, mental or psychiatric diseases?	
q. Any other disease or accidents suffered by the person to be insured?	
r. Does the person to be insured take or has ever taken narcotics or other habit forming drugs or been treated or advised in connection with your alcohol consumption or taking of drugs?	
6. Has the person to be insured under this health insurance proposal -	
a. Had any life/health/disability/cover declined/modified/postpones?	
b. Had an ECG, X-ray, blood/diagnostic test performed?	
c. Has any medication been prescribed in the past 12 months?	

	d. Been advised surgery but not yet done?	
	e. Receiving payment for disability/injury/illness?	
	f. Had a change in weight of >10 kgs in the last 6 months?	
	g. Been treated as an in-patient or out- patient for surgery?	
	h. Had any medical treatment for medical or physical impairment?	

Give details in table below for any other illness or disease or accident or operation sustained by the person to be insures in the past

Nature of illness/diseases/injury & treatment received	Date first treated	Name of attending medical practitioner/surgeon with his address & telephone number	Whether fully cured

Personal history for person to be insured (proposed)

Alcohol consumption (Units per Week)		
Tobacco consumption	Nature	
	Details	
	Units per week	
Any other drugs / substance of abuse	Nature	
	Details	
	Units per week	

Assignment:

In the event of the death of the person to be insured, all the benefits if any that shall become payable under the policy will be paid to the person named as the assignee by the insured person and his/her receipt shall be sufficient discharge to the company.

Name of the person proposed to be insured	Name of the assignee	Relationship (to the person to be insured)	Signature of the insured person (with date)

To be completed by the Proposer (for details wrt the proposed) in case of adverse medical history in the proposal form in respect of applicable illness

Diabetes questionnaire

1. When was Diabetes Mellitus detected?	
2. Does the person to be insured take any anti diabetic drugs? If so, give name with dosage.	
3. Please give details of fasting & Postprandial Blood Sugar readings, HbA1c report, ECG findings & other investigation reports. Please enclose latest reports	
4. Do you suffer or have suffered from any complication of Diabetes Mellitus?	

Hypertension questionnaire

1. What is your blood pressure reading?	
2. Please state Antihypertensive medications currently on with dosage?	
3. Is it essential / secondary?	
4. Please state whether the proposed has suffered from any complication of Hypertension?	
5. Please give findings of all investigation reports available	

Signature of the Proposer		Signature of the proposed	
Place:-		Place:-	
Date:-		Date:-	

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To be filled by consulting physician/Surgeon/Medical Examiner (in case of adverse medical history)

Name of the Proposed
Relevant history(if necessary please attach separate sheet)
Details of present & past medication with duration
General examination findings(in brief)

Signature of the Proposed		Signature of consulting physician	
Place:-		Name of consulting physician	
Date:-		Qualification and contact number	

Declaration: I hereby declare and warrant that the above statements are true and complete. I consent & authorize the insurer to seek medical information from any hospital/medical practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that the proposal shall form the basis of the contract should the insurance be effected. If after the insurance is affected it is found that the statements, answers or particulars stated in the proposal form and/or other questionnaire are incorrect or untrue in any respect the insurance company shall bear no liability under this policy.

I have read the prospectus and am willing to accept the coverage subject to the terms & conditions and expectations prescribed by the insurance company therein.

Signature of the Proposer		Signature of the proposed	
Place:-		Place:-	
Date:-		Date:-	