

3.1 Country of Studying of Posting: _____

3.2 Address in Country of Studying or posting: _____
_____ Tel. No. _____

3.3 Name and Address of School / Work place you are attending:

_____ Tel. No. _____

3.4 Brief details of nature of future studies/ research and activities/ or employment/ employment to be undertaken

_____ from _____ / _____ to _____
MM YY MM YY

4.1 Name and Address of Bangladeshi Sponsor : _____

_____ Relationship _____

5.0 Period of Insurance required : _____

5.1 Commencement Date : _____ / _____
D D MM YY

5.2 Total period of months that you are intending to study / work in the country of study / posting _____ months

6.0 YOUR MEDICAL HISTORY:
PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES OR NO (A DASH IS NOT SUFFICIENT)

6.1 Are you in good health and free from physical defect or infirmity?

6.2 Do you ordinarily enjoy good health?

6.3 Have you ever suffered from? _____

- a) Any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind? _____
- b) High blood pressure, a heart condition, hemorrhoids, varicose veins, or other circulatory disorder, rheumatic fever or diabetes? _____
- c) A "slipped disc" or other spinal disorder, a hernia, or any rheumatic or arthritic condition? _____
- d) Any respiratory, urinary or allergic condition or any disorder of the stomach or bowels? _____
- e) Any other condition requiring specialist consultation or surgical or hospital treatment? _____
- f) Any symptom or tendency that might necessitate such consultation or treatment in the future? _____

6.4 Have you any intention of engaging in winter sports or any other sports or pastimes rendering you liable to personal injury?

6.5 Are there any additional facts affecting the proposed insurance which should be disclosed to Insurers 6.6

Name and address of usual medical physician in Bangladesh?

_____ Tele No. _____

7. DECLARATION:

Please read IMPORTANT NOTES above before your signing.

I hereby declare and warrant that the above statements are true and complete. I consent to the Corporation / Company and /or their appointed Claims Administrator seeking medical information from any Doctor who has at any time attended concerning anything which affects my physical or mental health, and I authorize the giving of such information. I agree that this Proposal shall form the basis of the contract of Insurance.

I am willing to accept the Policy, subject to the terms, exceptions and conditions prescribed by the Corporation/ Company therein.

Date: ___ / ___ / _____ Signature: _____
DD MM YY

Place: _____

11.0 STUDY (Plan `C'- Worldwide excluding USA & Canada) and (Plan `D'- Worldwide including USA & Canada):

If you are under 18 years old and / or residing with your parent(s), one of your parents must confirm the accuracy of the information provided in this proposal by signing below :-

Signature of Parent (or Guardian) _____

Date: _____
DD MM YY

Place: _____

12.0 EMPLOYMENT (Plan `C'- Worldwide excluding USA & Canada) and (Plan `D'- Worldwide including USA & Canada):

If you are being posted overseas by an Employer, the competent official of your Company must confirm the accuracy of the information provided in this proposal by signing below:-

Employer's competent official's signature :

Date: ___ / ___ / _____
DD MM YY

Place: _____

I M P O R T A N T

IF YOU ARE NOT ABLE TO SIGN THIS DECLARATION AND WARRANTY AT THE TIME OF PROPOSAL OR HAVING SIGNED THE DECLARATION AND THEREAFTER CIRCUMSTANCES CHANAGE BEFORE THE FIRST DAY OF INSURANCE WHEREBY THE DECLARATION IS RENDERED INVALID, YOU MUST INFORM CORPORATION/ COMPANY FOR FURTHER ADVICES.

U N D E R T A K I N G

I, Mr. / Mrs. / Miss / Master

do hereby agree and undertake to refund to Corporation/ Company providing the insurance (hereinafter referred to as the Insurers) all medical related expenses, made by insurer's Claims Administrators on my behalf which expenses are found to be not payable as per terms and conditions of the Policy and which expenses are required to be reimbursed by the Insurers to the Claims Administrator under the agreement made between the Insurers and their Claims Administrator. Such payments would be refunded by me to the insurers in Bangladesh TAKA immediately

Date: ___ / ___ / _____ Signature of Proposer: _____
DD MM YY

Place: