AsthaLife
সুরক্ষিত জীবনের প্রতিশ্রুতি

Astha Life Insurance Company Ltd
Health Insurance Policy

Application Form

Application No.----------

(Please use block letters although)

No insurance cover will apply in respect of any condition or linked condition which exists or has existed before the acceptance of risk unless it has been declared and accepted by Astha Life Insurance Company Limited. It is therefore in your interest to answer these questions fully and provide information if in doubt.

Name of Proposer: ----------

Name of Father / Husband: ----------

Mailing Address: ----------

Date of Birth: _____/_____/_____/ **Age:** ---------- **Gender:** ---------- **Marital Status:** ----------

Occupation: ---------- **Nature of work:** ----------

Type of Cover: **Single** ☐ **Couple** ☐ **Family** ☐

Health Insurance (HI) Plan: Plan I ☐ **Plan II** ☐ **Plan III** ☐ **Plan IV** ☐ **Plan V** ☐ **Plan VI** ☐

Dependents to be included in the Policy

Name	DOB	Relation	Gender	HI Plan	Premium

Health Declaration

(Please tick √ in the space provided below & use additional papers if required).

a. Have you or any member of your family (to be included in this Policy) suffered from any illness, injury, disability or impairment for a period of more than 10 days in the last 5 years?

b. Have you or any member of your family (to be included in this Policy) in the last 5 years consulted a specialist or attended a clinic as an outpatient or in-patient for an investigation, treatment or operation?

c. Have you or any member of your family (to be included in this Policy) in the last 5 years consulted any doctor about any condition or impairment which still exists or has left any residual effect?

d. Are you or any member of your family (to be included in this Policy) habituated or addicted to smoking, alcohol or drugs?

e. Are you or any member of your family (to be included this Policy) currently receiving any medical treatment or medication or on a special diet or expecting to consult a doctor, in connection with any illness, injury, disability or impairment for which symptoms are known evident or suspected?

f. Have you or any member of your family (to be included in this Policy) at any time been postponed, declined, or accepted subject to special terms by any insurance company for a life insurance policy?

g. Are you or any member of your family (to be included in this policy) covered for similar benefits under health insurance policy?

h. Is there any other information relating to the health of you or any member of your family (to be included in this Policy) that you should declare?

If any of the above answer is 'yes' please give the details in below:

Question Number	Applicant/Dependent Name	Details

In the case of Female

a. Are you pregnant now? Yes ☐ No ☐

b. Did all pregnancies end in normal delivery? Yes ☐ No ☐

Declaration

I declare that

a. The statements made in this Proposal Form are true and complete to the best of my knowledge and belief and that I have not withheld any information knowingly.

b. I understand that this insurance cover will not be effective until this Proposal Form has been accepted by the Company and the full premium received.

c. If after the date of submission of this Proposal from but before the issue of the Policy document any change of occupation or any adverse circumstance connected with the general health of myself or that of any member of my family (to be included in the Policy) occurs, I shall forthwith intimate the same to the Company in writing.

Full name, Signature with date of Applicant: ----------

Financial Associate Sign, Code with date: ----------

Unit Manager/Branch Manager Sign, Code with date: ----------