Fairfirst Worldwide Healthcare Application Form

Please read the questions carefully before fill and complete using BLOCK CAPITAL letters.
Tick the boxes where necessary.
Al material facts to be disclosed appropriately.

1) Your Personal Information

Title	Mr ☐	Mrs ☐	Miss ☐	Mast ☐	Dr ☐	Prof ☐	Rev ☐								**Gender**	Male ☐	Female ☐						

First Name															**Middle Name (s)**								
Surname																							
Home Address																							
Corresponding Address (If different to the above)																							
Date of Birth	DD		MM		YYYY										**NIC/Passport No**								
Telephone No															**Mobile No**								
Email Address															**Nationality**								
Employer's Name and address (If any)															**Occupation**								
Principle Country of Residence (If not in Sri Lanka)																							

2) Select your plan

Cover Commencement Date	D	D	M	M	Y	Y	Y	Y															

		Plan 1 ☐	**Plan 2** ☐	**Plan 3** ☐	**Plan 4** ☐
ANNUAL MAXIMUM BENEFIT		**$ 500,000**	**$800,000**	**$ 1,000,000**	**$ 1,500,000**
Geographical Zone I	☐	Sri-Lanka, India, Thailand, Malaysia	Asia	Worldwide excl. USA & Canada	Worldwide excl. USA & Canada
Geographical Zone II	☐	Asia	Worldwide excl. USA & Canada	Worldwide	Worldwide

If you are a switch applicant who is enjoying an International Medical policy, please tick	☐	**Existing Policy No**	
		Existing Insurer	
		Policy Expiry	D D / M M / Y Y Y Y

If you are interested in reducing the premium with a voluntary deductible, please select below

$500 with 10% discount	☐	$1,000 with 15% discount	☐	$2,500 with 22.5% discount	☐
$750 with 12.5% discount	☐	$2,000 with 20% discount	☐		

If you are purchasing additional covers with premium, please select OPD ☐ OPD + Dental & Vision ☐

3) Your Family Details

Title	First Name	Middle Name	Surname	Relationship	Date of Birth	NIC / Passport No	Nationality	Occupation	Residence Country
				Spouse	DD / MM/ YYYY				
				Child	DD / MM/ YYYY				
				Child	DD / MM/ YYYY				
				Child	DD / MM/ YYYY				

If there are additional family members to cover, please add them in a separate sheet. ☐

4) Medical declaration

If you are presently or had been diagnosed/suffered/treated for any of the following conditions, and your answer to any of the below questions are 'Yes' kindly provide details pertaining to the respective ailment / illness along with any medical records. Based on the info provided Insurer may call for any additional medical records or screening, if necessary.

No	Medical Questions	Applicant	Spouse	Child	Child	Child
1	Height (cm)					
	Weight (kg)					
2	Cancer, tumor, polyp or cyst (benign or malignant)					
3	Any heart disease or disorder, chest pain or discomfort, irregular heartbeats, palpitations or heart murmur					
4	Hypertension/ High Blood pressure (BP)/ High Cholesterol					
5	Asthma/ Tuberculosis (TB)/ COPD (chronic obstructive pulmonary disease)/ Pleural effusion/ Bronchitis/ Emphysema or any other disease of Lungs, Pleura and airway or respiratory disease					

6	Thyroid disease/ Cushing's disease/ Parathyroid disease/ Addison's disease/ Pituitary tumor/ disease or any other disorder of Endocrine system					
7	Diabetes Mellitus/ High Blood Sugar/ Diabetes on Insulin or medication					
8	Motor Neuron disease/ Muscular dystrophies/ Myasthenia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)					
9	Stroke/ Paralysis/ Transient Ischemic Attack/ Multiple Sclerosis/ Epilepsy/ Mental-Psychiatric Illness/ Parkinsonism/ Alzheimer's/ Depression/ Dementia or any other disease of Brain and nervous system					
10	Cirrhosis/ Hepatitis/ Wilson's disease/ Pancreatitis/ Liver disease/ Crohn's disease/ Ulcerative Colitis / Piles or any other disease of Mouth, Esophagus, Liver, Gall Bladder, Stomach or Intestines or any other part of digestive system					
11	Kidney stones/ Renal failure/ Dialysis/ Chronic Kidney Disease/ Prostate Disease or any other disease of Kidney, Urinary Tract, or reproductive organs					
12	Human Immunodeficiency Virus (HIV)/ Systemic lupus erythematosus (SLE)/ Arthritis/ Scleroderma/ Psoriasis/ bleeding or clotting disorders or any other disease of Blood, Bone Marrow, Immunity or Skin					
13	Disease or Disorder of eye, ear, nose, or throat (except any sight related problems corrected by prescription lenses)					
14	Smoke, consume alcohol, or chew tobacco or use any recreational drugs - Liquor (ml amount per week) - Smoking (no of sticks per day) - Other (volume per day)					
15	Any other disease/ health adversity/ injury/ condition/ treatment not mentioned above					
16	Have you been hospitalized/ recommended to take investigation/ medication or has been under any prolonged treatment/ undergone surgery for any illness/ injury					

5) Switch Details

No	Details	Applicant	Spouse	Child	Child	Child
1	Have you filed a claim with your current/previous insurer? If Yes, please provide details on a separate sheet					
2	Has any of your proposal(s) for Health insurance been declined, cancelled, charged a higher premium, or issued with special condition(s)?					
3	Is any of the person(s) proposed for insurance covered under any other health insurance policy with the Company or any other Company without break?					

6) Reimbursing your Insurance Claim

When a claim is submitted on reimbursement basis under the policy, please tick the relevant box you required how you need us to settle your claim.

Cheque ☐ Bank Transfer ☐

If bank transfer, please mention the following details.

Bank Name		Branch Name	
Bank Code		Branch Code	
Account No			

Declaration

I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and / or particulars given by me are true and complete in all respects to the best of my knowledge and that I am authorized to propose on behalf of family who resides in Sri Lanka only.

I understand that the information provided by me will form the basis of the insurance contract, subject to approved underwriting policy of the insurer and that the policy will come into force only after full payment of the annual premium.

I further declare that I will notify in writing any change occurring in the occupation or general health of the life to be insured / proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

I declare that I consent to the company seeking medical information from any doctor or hospital who / which at any time has attended on the person to be insured/ proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be insured / proposer and seeking information from any Insurer to whom an application for insurance on the person to be insured / proposer has been made for the purpose of underwriting the proposal and / or claim settlement.

I authorize and permit the company to share information pertaining to my proposal including the medical records of the Insured/ Proposer for the sole purpose of underwriting the proposal and / or claim settlement and with any Governmental and / or Regulatory authority.

I/We agree to follow the claims procedure stipulated in the Policy Document “6. CLAIMS” (Page 23 to 25).

I/We declare that to the best of my/our knowledge and belief that all the information given in this Proposal are true and accurate in every respect, and if such statements been answered by another person, he / she acted as my / our agent for such purpose

DD/MM/YYYY		
.....	.....	.....
Date	**At**	**Signature**

For Office use only

Broker Name		**Broker Code**	
Sales Name		**Sales Code**	
Branch Name		**Branch Code**	
Channel Name		**Quotation No**	