Fairfirst Worldwide Healthcare

Application Form

Please read the questions carefully before fill and complete using **BLOCK CAPITAL** letters.

Tick the boxes where necessary.

All material facts to be disclosed appropriately.

# Your Personal Information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | Rev/Ven |  | Prof. |  | Dr. |  | Mr. |  | Mrs. |  | Ms. |  | Miss. |  | **Gender** | Male |  | Female |  |
|  |
| **Full Name (underline the surname)** |  |
|  |
| **How do you want your name to appear on the card** |
|  |
|  |
| **If the policy to be issued on Company name, please mention the name of the Company** |
|  |
| **Company Address** |  |
| *\*Ps Attach a copy of the business registration, VAT / SVAT registration (if any)* |
|  |
| **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)** |  |

# 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 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 wish to extend the cover with additional premium, please tick appropriately** | OPD |  |  | OPD + Dental & Vision |  |
|  |  |

# Your Family Details (Only if the dependants need to be covered)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | **First Name** | **Middle Name** | **Surname** | **Relationship** | **Date of Birth****(DD/ MM/ YYYY** | **NIC / Passport****No** | **Nationality** | **Occupation** | **Residence Country** |
|  |  |  |  | Spouse |  |  |  |  |  |
|  |  |  |  | Child |  |  |  |  |  |
|  |  |  |  | Child |  |  |  |  |  |
|  |  |  |  | Child |  |  |  |  |  |
| If there are additional family members to cover, please add them in a separate sheet |  |

# 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 underline the appropriate ailment / illness listed out there, and 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 |  |  |  |  |  |

# Switch Details

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 continuously ? |  |  |  |  |  |

# 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 |  |

Account details can be submitted at the time of a claim as well. Please share the account details along with the claims documents.

# 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. Further I/We agree to sign the attached consent for Personal Data Protection and other related provisions in laws and regulations (in accordance with the Personal Data Protection Act, no. 9 of 2022 and Regulations of Central Bank no. 03/2020 and dated 12/30/2020)

I/We agree to follow the claims procedure stipulated in the Policy Document “7. CLAIMS” (Page 26 to 28).

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 Signature**

**\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_**

**For Office use only**

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