



GLOBAL TRAVEL INSURANCE PROPOSAL FORM

PROPOSER DETAILS

Name : (Mr./Ms./Mrs./Entity):					
Correspondence Address :					
Country where Business is operated(Entity) :					
Permanent Address:					
Mobile Number:		Telephone Number:			
Email:		Website:			
Date of Birth/Incorporation(For Entity):					
Gender:			Male <input type="checkbox"/>		Female <input type="checkbox"/>
					Others <input type="checkbox"/>
Nationality:					
Proof of Identity:			Citizenship Card <input type="checkbox"/>		Passport <input type="checkbox"/>
			Driving License <input type="checkbox"/>		Trade License <input type="checkbox"/>

POLICY DETAILS

Proposed Policy Period Start Date:						Proposed Policy Period End Date:					
Cover Type:			Individual <input type="checkbox"/>			Family <input type="checkbox"/>					
Trip Type:			Single <input type="checkbox"/>			Multi <input type="checkbox"/>					
Purpose of Travel:			Business <input type="checkbox"/>		Adventure <input type="checkbox"/>		Sports <input type="checkbox"/>		Pleasure <input type="checkbox"/>		Vacation <input type="checkbox"/>
			Pilgrimage <input type="checkbox"/>		Student Plan <input type="checkbox"/>		Others (Please Specify)		High Altitude <input type="checkbox"/>		
Place of Travel											
Accommodation Address:											
Emergency Contact Number:											
Emergency Email ID:											

ZONE*	GEOGRAPHICAL SCOPE	PLAN*
<input type="checkbox"/> ZONE 1	WORLDWIDE INCLUDING USA, CANADA, AUSTRALIA & JAPAN	STANDARD <input type="checkbox"/> GOLD <input type="checkbox"/>
<input type="checkbox"/> ZONE 2	WORLDWIDE EXCLUDING USA, CANADA, AUSTRALIA & JAPAN	STANDARD <input type="checkbox"/> GOLD <input type="checkbox"/>

*Please tick one plan depending on the geographical area that you are planning to travel.



DETAILS OF THE PERSONS TO BE INSURED INCLUDING PROPOER

Insured No:___ Name : (Mr./Ms./Mrs./Entity)			
Marital Status:		Date of Birth:	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>	Passport Number	
CID Number		IF PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>	
Occupation:			
Relationship with Proposer:		Address	
Insured No:___ Name : (Mr./Ms./Mrs./Entity)			
Marital Status:		Date of Birth:	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>	Passport Number	
CID Number		IF PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>	
Occupation:			
Relationship with Proposer:		Address	
Insured No:___ Name : (Mr./Ms./Mrs./Entity)			
Marital Status:		Date of Birth:	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>	Passport Number	
CID Number		IF PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>	
Occupation:			
Relationship with Proposer:		Address	
Insured No:___ Name : (Mr./Ms./Mrs./Entity)			
Marital Status:		Date of Birth:	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> Others <input type="checkbox"/>	Passport Number	
CID Number		IF PEP* : Yes <input type="checkbox"/> No <input type="checkbox"/>	
Occupation:			
Relationship with Proposer:		Address	

Note 1: Please mention the insured number serially beginning from the number 1 and then 2,3,4,... so on respectively

Note 2: Where the cover type is individual, the minimum entry age shall be 2 days.



DETAILS TO BE FILLED

1. Is any of the member proposed to be insured suffering from any illness or disease? If yes, please provide the details below:
Disease(s) : E.g. Cancer/ Tumor, Coronary Artery Heart disease, Insulin Dependent Diabetes, Paralysis/ Stroke, Congenital Disease, HIV/ AIDS/ STD, Liver Disease, Kidney Disease, Thalassemia Major, Other (Please Specify)

Please mention the insured no & Disease: Example: Insured No:1 - Cancer

2. Has anyone been diagnosed/hospitalized or under any treatment for any illness/injury in the past? If yes, please provide the details below:

Please mention the insured no. & specify:

3. Have you ever claimed under any travel policy? If yes, please provide the details below:

Please mention the insured no. & amount: Example: Insured No:1 – Amount : USD 5000

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 these other persons.
- I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurer and that the policy will come into force only after full payment of the premium chargeable.
- 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 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.

Signature of the Proposer:

Date:

Place: