



Hospitalization Plan Proposal Form

For Bangabandhu Sheikh Mujibur Rahman Agricultural University (BSMRAU)

INSTRUCTIONS: It is very important that complete medical history is disclosed in this form. Please note that if a pre-existing medical condition/illness is NOT DISCLOSED, we can decline the claim relating to it. If the medical condition is disclosed, we may cover that medical condition. Therefore, it is in your best interest to disclose complete medical history.

Pre-Existing medical conditions are diseases, illnesses, or injuries for which a person receives treatment, incurs expenses, receives a diagnosis from a doctor (even if no treatment is provided) or was aware of at any time prior to applying for insurance.

Name of Employer :			
Name of Employee :			
Name of Employee(Bangla):	Designation:		
Office Address:			
Permanent Address:			
Date of Birth:	Date of Joining:	Gender :	
Marital Status:	Mobile No.:		

1) Are / have you currently or at any time prior to applying for insurance:	YES	NO
a. Suffered from any medical condition / disease / illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
b. Aware of any Pre-existing condition/medical condition / disease / illness or injury (even if no doctor was consulted)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Received diagnosis from a Doctor or Homeopath (even if no treatment was provided)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Taking or been advised to take any medication for more than 7 continuous days?	<input type="checkbox"/>	<input type="checkbox"/>
e. Suffered from any physical or mental disability?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you smoke any form of tobacco or consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
4) Are you pregnant (female applicants only)? If yes, provide details.	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "YES" to any of the question 1)a. to 1)e. above, please provide details below: Attach additional sheets if necessary. Please attach photocopies of the relevant medical reports.

Name	Description of Diseases	Attending/Treating Doctor (Name, Address & Hospital)

DECLARATION: I hereby declare that the statement above is true and complete to the best of my knowledge and belief. I have not withheld any information. I understand that this health declaration form together with the application of my employer to Pragati Insurance Limited is the basis for the Group Health Insurance applied for. I hereby authorize any hospital, physician or surgeon who has attended me or my family members to furnish to Pragati with any and all information that they may require concerning our medical history and/or examinations.

.....
Signature of Employee & Date

TO BE FILLED BY THE EMPLOYER

Please specify the plan for this employee

- Royal Corporate Super
- Standard Basic Other

Coverage Effective Date:.....

.....
Signature & Stamp of the Employer