Pragati Insurance Limited

Stamp Size Photo
(2 Copy)

Hospitalization Plan Proposal Form

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:		Telephone No.(If Any):		Gender :	Male/Female
Marital Status:	Married/Unmarried		No. of Child (If Any):		

Please list Family Members (spouse, son and daughter) to be covered:

Sl. No.	NAME Please write in CAPITAL letters	Relationship with You	Date of Birth (dd/mm/yyyy)	For Official Use
1				
2				
3				
4				

1. Are/have you or any member of your family (spouse/children/parents) currently or at any time prior to applying for insurance:

Sl #	Particular	Yes	No
a.	Suffered from any medical condition / disease / illness or injury?		
b.	Aware of any medical condition/disease/illness or injury (even of no doctor was consulted)?		
c.	Received diagnosis from a Doctor or Homeopath (even if no treatment was provided)?		
d.	Taking or been advised to take any medication for more than 7 continuous days?		
e.	Suffered from any physical or mental disability?		

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 of the Person whom 'Yes' answer has been given	Please describe medical condition and its duration, treatment received, investigations under taken and results. Is any further tests or treatment suggested or required?	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 to 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 for Self & on behalf of family members being covered _____ 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