SOLARELLE GLOBAL HEALTH CARE INSURANCE

Please fill in Block Capitals

1. Your personal details
   Proposer's Full name Mr./Mrs./Ms.----------
   Surname: ----------
   First Name: ----------
   Other Initials: ----------
   NIC No / Passport No: ----------
   Nationality: ----------
   Gender (M/F): ----------
   Date of Birth (dd/mm/yy): ----------
   Occupation: ----------
   Postal Address: ----------
   Mobile No: ----------
   Email: ----------
   Period of Insurance: From ----------To----------

2. **Plan Details**
   Please tick (✓) to indicate the type of plan.

Worldwide Excluding USA/Canada	Plan 1	50,000	
	Plan 2	35,000	
	Plan 3	25,000	
India Subcontinent + South East Asia excluding Singapore & Thailand	Plan 1	50,000	
	Plan 2	35,000	
	Plan 3	25,000	

3. Health Declaration

All information supplied will be treated as strictly confidential. All material facts including those relating to these questions must be disclosed. Failure to do so many invalidate the policy. A material fact means any information that would be likely to influence the insurer's assessment and acceptance of this application form. If you are in any doubt whether a fact is material, then it should be disclosed.

		Yes	No	If Yes, please give details
1	Are you currently suffering from any complaints, illness, after-effects of Accidental, Mental or Physical			
2	Have you ever suffered from, or been in hospital with or received treatment, done tests or investigations for			
	a) Rheumatism, Gout, arthritis or disease of the Muscles or joints including the back			
	b) Epilepsy or other Neurological disorders			
	c) Any Digestive disorder including Stomach and/or bowel problems			
	d) Anxiety, Depression or Psychiatric or Mental illness			
	e) Gynecological disorders			
	f) Any disorders of the kidneys, bladder or liver Pancreas including diabetes			
	g) Any lump, cyst, mole or cancer			
	h) Any skin disorders			
3	Have you ever been advised to consult a doctor for a recurrent complaints, or been advised to have any diagnostic investigations/tests or treatment which has not been completed or that you still await the result of?			
4	Have you been tested for HIV-antibodies? If yes, please state the result of HIV test?			
5	Have you ever suffered from or been in hospital for any other disorder or as a result of an accident which required that you			
	a) Received more than 14 days treatment?			
	b) Whether you are "off work" for more than one week?			
	c) Had any specialized consultation / treatment for any ailment?			
6	Are you pregnant? Please state expected date of childbirth			
7	Have wither of your parents or any of your brothers or sisters, living or diseased, suffered before the age of 65, from diabetes, heart disease, high blood pressure, Cancer, Kidney disease, raised cholesterol, Nervous or Brain disorder such as Alzheimer's, Parkinsonism, or Multiple Sclerosis, Eye Ailments, Hearing Loss or any familial congenital disorders?			
8	Have you ever had screening for cancer or general medical check-ups within the last 5 years?			
9	Height / Weight	Kg		Cm

4. Health Declaration

Please state the name, address and telephone numbers of your family Doctor and Dentist or details of your last consultation;

Full name Mr./Mrs./Ms.----------

Surname: ----------

First Name: ----------

Date of last visit (dd/mm/yy): ----------

Address: ----------

Mobile No: ----------

5. Dental Declaration

(Should only be completed if you are purchasing dental cover)

		Yes	No	If Yes, please give details
1	Are you currently undergoing or have you been advised to undergo any dental treatment?			
2	Do you have missing teeth which have not been replaced (Excluding wisdom teeth)?			
3	Have you wear denture sets (crowns, inlays, implants, bridges, fillings etc.)?			
4	Do you suffer from parodontosis?			
5	Have you undergone a dental checkup within last five years? When and what was the result			
	Date:			
	Outcome:			

6. Declaration

a) I declare that al information supplied above is true and complete, including those answers that are not handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contact between Solarelle Insurance Pvt Ltd and me, and that any false, incorrect or misleading statement may render this insurance null and void.

b) I undertake to perform Solarelle Insurance Pvt Ltd immediately in writing of any changes in my state of health occurring after the application has been signed and before the commencement date.

c) I understand I can withdraw my application in writing by letter or e-mail, within 14 days from the policy commencement date and provided that I have not submitted a claim, I'm entitled to a refund of the premium based on company short period scale.

d) I consent to the fact that Solarelle Insurance Pvt Ltd, if it considers it appropriate, will check statement concerning my health condition and will check with other health insurers all statements concerning previous, or existing contracts applied for.

e) I accept that this policy will be subject to the standard policy terms and condition effective at the time of policy commencement. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy including the exclusion relating to pre-existing conditions.

Applicants Signature ---------- Date ----------