গার্ডিয়ান লাইফ ইন্স্যুরেন্স লিমিটেড
Guardian Life Insurance Limited

প্রধান কার্যালয়ঃ ছিদ্দিক টাওয়ার (১১ ও ১২ তলা), ৪৯, মহাখালী বা/এ, ঢাকা-১২১২
ফোনঃ +৮৮ ০২ ৯৮৮৮৪২২-২৪, ফ্যাক্সঃ +৮৮ ০২ ৯৮৮৮৩৯৯, ওয়েবঃ www.guardianlife.com.bd

HEALTH INSURANCE APPLICATION FORM

1. Affixed to Proposal No: .... Employee ID ....
2. Name of Applicant : .... DOB : dd/mm/yyyy Sex : ☐ M ☐ F
3. **Plan option:**
   Bronze ☐ Bronze Plus ☐ Silver ☐ Silver Plus ☐ Gold
   Gold Plus ☐ Platinum

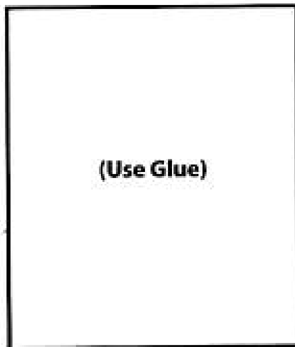
   Coverage option:
   ☐ Self ☐ Couple (Husband & Wife)
   ☐ Family (Husband, Wife & Dependent Children)

4. Spouse Name: .... DOB: dd/mm/yyyy Sex: ☐ M ☐ F Occupation: ....

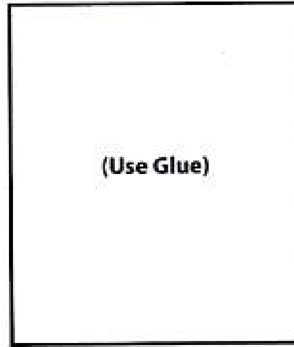
5.	Name of dependent unmarried children under the plan	Sex	DOB	Occupation (if any)	Relationship

6. Do you want to take maternity coverage? ☐YES ☐ NO Plan Option ☐Standard ☐ Deluxe

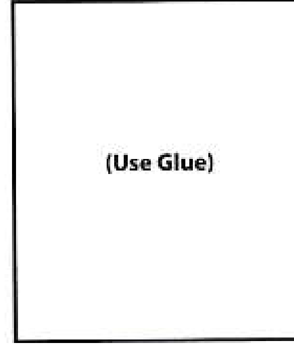
7. Please stick one passport size photograph for each person to be covered under the plan.



Self

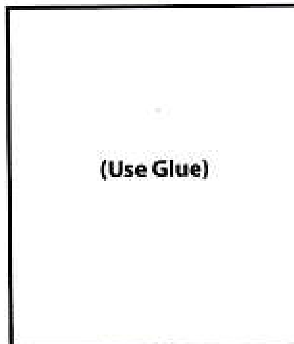


Spouse

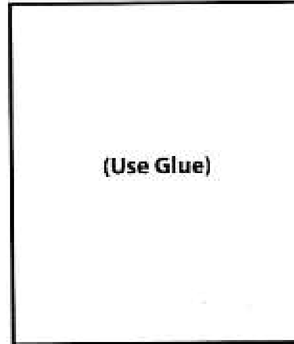


Child-1

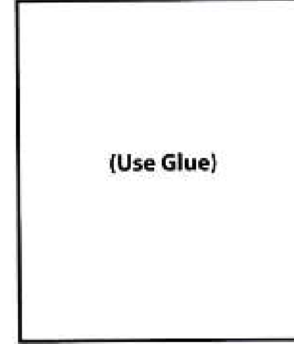
Child-2



Child-3



Child-4



Others

8. HEALTH QUESTIONNAIRE

No insurance cover will apply in respect of any condition or related conditions, which exists or has existed before the acceptance of risk by Guardian Life Insurance Limited unless it has been declared to and accepted by Guardian Life Insurance Limited. It is therefore in your interest, answer these questions fully and provide accurate information.

A. Currently are you or any of the dependents to be included in the plan-		
1. suffering from tuberculosis, diabetes, asthma, rheumatic fever, heart disease, hypertension, epilepsy, kidney disease, genitor-urinary or gynecological disorder, cataract, cancer, mental illness, hernia, any disease of recurring nature or any chronic illness?		☐ YES ☐ NO (If yes, please specify)
Name of person	**Disease**	**Duration**

2. receiving any treatment or on a special diet or on regular checkup or have symptoms of any illness injury, disability, impairment which are known, evident or suspected?	☐ YES ☐ NO (If yes, please specify)
Name of person	**Details**

3. Covered under any health insurance policy from any other insurance company for similar benefits?		☐ YES ☐ NO (If yes, please specify)
Name of person	**Insurer**	**Benefit limit & date of commencement**

B. Currently are you or any of the dependents to be included in the plan-			
1. been incapacitated for a period of minimum five days due to injury, illness, disability, impairment or admitted to a hospital/clinic/sanatorium for treatment or operation ?			☐ YES ☐ NO (If yes, please specify)
Name of person	**Reason**	**Date**	**Current situation**
2. consulted a specialist or attended a hospital/clinic as an out-patient for the purpose of operation, investigation or X-ray ?			☐ YES ☐ NO (If yes, please specify)
Name of person	**Reason**	**Date**	**Current situation**

C. At any time, have you or any of the dependents to be included in the plan			
1. suffered from any illness, impairment, deformity or disability which still exists or recurring in nature or has left any residual effect or required major surgery, care in ICCU/CCU or long term treatment?			☐ YES ☐ NO (If yes, please specify)
Name of person	**Reason**	**Period**	**Current situation**
2. been postponed, declined, or accepted on special terms by any insurance company for a life or health insurance policy			☐ YES ☐ NO (If yes, please specify)
Name of person	**Insurer**	**Reason**	**Type of insurance and date of cover**

D. Any married female to be included in the plan		
1. is pregnant now?		☐ YES ☐ NO (If yes, please specify)
Name of person	**Duration of Pregnancy**	**EDD (if known)**
2. had complication in any of her previous pregnancy or delivery?		☐ YES ☐ NO (If yes, please specify)
Name of person	**Name of complication**	**Mode of delivery**

E. Is there any additional information relating to the health of yourself or any of the dependents to be included in the plan which is not yet mentioned, e.g. a pre-existing condition or congenital anomaly ?	☐ YES ☐ NO (If yes, please specify)
Name of person	**Details**

9.	Are you smoker?	☐ YES ☐ NO (If yes, please specify) Number of Cigarettes/Day.................................Brand..

DECLARATION

I declare that the information given in this application are true and complete to the best of my knowledge. It is agreed that declaration and information given in this application together with any supplementary, declarations or disclosures made by me shall form of the basis of my/our insurance is effected if it is found that the information furnished in this form incorrect or untrue, the company shall have the right to decline any claim relating to such information.

Place:.. Date: dd mm yyyy

Signature of the Applicant