Allianz Insurance Lanka Ltd.
Company No: PB 5179
Levels 26-27, One Galle Face Tower, No. 1A, Centre Road, Galle Face, Colombo 02.
Tel : 0112 303 300 | Fax : 0112 309 999 | Website: www.allianz.lk | E-mail: info@allianz.lk

ALLIANZ GLOBAL HEALTHCARE PROPOSAL FORM

Please Fill In Block Capitals. (Note: Any alterations in this proposal form must be signed)

1. Proposer's Details

Full name: Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Rev. ☐ Other ______

NIC /Passport no: ______ (NIC is mandatory for Sri Lankans)

Date of birth D D M M Y Y Y Y Gender: Male ☐ Female ☐

Home country Sri Lanka ☐ Other ☐ ______

Current country of residence (Work & Live) Sri Lanka ☐ Other ☐ ______

Nationality: Sri Lankan ☐ Other ☐ ______

Full address in current country of residence (mandatory) ______

Occupation: (Mandatory) ______ Primary phone number ______

Secondary phone number ______ E-mail ______

Period of insurance: from D D M M Y Y Y Y to D D M M Y Y Y Y

Details of any current domestic or international health insurance:

Name of insurer ______ Policy number ______

Start date D D M M Y Y Y Y

2. Plan Details

Please tick (√) to indicate the type of plan you desire to select

CORE PLAN		Limit
CLASSIC PLAN - Singapore, Malaysia, Thailand, Sri Lanka & India	☐	**USD 800,000.00**
GOLD PLAN - Worldwide excluding USA / Canada	☐	**USD 1,000,000.00**

VOLUNTARY EXCESS

Excess Per Annum	Discount in Premiums
☐ USD 1,000	5.00%
☐ USD 2,000	10.00%
☐ USD 4,000	15.00%
☐ USD 8,000	20.00%

Classification: Internal

3. Health Declaration

All information disclosed will be treated as 'strictly confidential'. All material facts relating to the questions should be disclosed. Failure to do so may 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.

Please underline the relevant ailment	YES	NO
(a) Have you ever had or been told to have or been treated for:		
i) epilepsy / fits, stroke, paralysis / weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous / mental disorders?	☐	☐
ii) ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose and throat?	☐	☐
iii) asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, breathing complaints / discomfort or any other lung disorders?	☐	☐
(b) Have you ever had or been told to have or been treated for:		
i) raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, fast heart rate, chest pain, or any disease or disorders of the heart or blood vessels?	☐	☐
ii) diabetes mellitus, thyroid disorders or any endocrine disorders?	☐	☐
iii) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	☐	☐
iv) jaundice, hepatitis-B carrier or any form of hepatitis, liver or gallbladder disorder?	☐	☐
v) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐	☐
vi) cancer, tumour, cyst or growth of any kind?	☐	☐
vii) slipped disc, backache, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐	☐
viii) any sexually transmitted disease, e.g. syphilis, gonorrhoea, non-specific urethritis, herpes, HIV infection or AIDS?	☐	☐
ix) endometriosis, fibroids, cysts, breast lumps, abnormal pap smear, irregular or painful menstruation or any other disorders of the female organs?	☐	☐
x) anaemia, haemophilia or any disorders of the blood?	☐	☐
xi) any other illnesses, disorder, operation, physical disability, accident, hospitalisation, congenital or hereditary disorders not listed above?	☐	☐
(c) Do you have a regular doctor? If 'Yes', please state the name and address of your regular doctor and the date, reason and result of last consultation.	☐	☐
(d) Have you consulted any doctor/specialist and had investigations done (X-Ray, ultrasound, Electrocardiogram, blood or urine tests) and/or prescriptions, provided for any drugs or medications for any medical conditions other than common illness e.g. flu, common cough etc? If 'Yes', please state details such as reason, date and results of test done and the diagnosis	☐	☐

(e) Have you been recommended by a doctor to receive any medical treatment, undergo any medical tests, investigations (excluding voluntary health check-up) or any intention to consult any doctor for any reason, seek further treatment or alternative medicine? If 'Yes', please state details such as type, reason, date and results of test done and the diagnosis.	☐	☐
(f) Do you engage in activities that will increase the likelihood of exposure to any immunity disorder such as AIDS or AIDS-related conditions or in the last 3 months had experienced the following symptoms for mo re than one week continuously: fatigue, weight loss, diarrhoea or unusual skin lesions? If 'Yes', please state details	☐	☐
(g) Have you ever been accepted at special terms or rates, deferred or declined for any application, renewal, or reinstatement of life, accident, health disability or other insurance policy? If 'Yes', please provide details on date of application and reason for special terms.	☐	☐
(h) Do you engage or have any intention of engaging in hazardous activity or occupation such as private flying, scuba diving, motor racing, mountaineering etc? If 'Yes', please state details such as locations, frequency, depth, etc.	☐	☐
(i) Have any of your natural parents or siblings died or suffered from (a) heart disease, (b) high blood pressure, (c) stroke, (d) diabetes, (e) cancer, (f) kidney disease, (g) mental disorder, (h) muscular disorder, or any other hereditary di sease? If 'Yes', please state relationship, condition, age of incidence of disease and age of death (if deceased)	☐	☐

Relationship	Condition/Cause of Death	Age at Onset	If Deceased, Age of Death

Additional information for "Yes" answers

If you answered Yes to any part of the question no 3 within the previous Health Declaration section, please provide details in the table below. Please tell us if a full recovery has been made or if you have any medical condition or disease related to or arising from the original diagnosis.

Please enclose supporting up-to-date medical reports/test results if possible.

Question number	Diagnosis - illness or aliment (Please enclose supporting documents)	Exact date of onset of the condition	Frequency and severity of symptoms and date of last symptoms	Past and current treatment (dosage and frequency of usage of medication and type of treatment) provide dates of when treatment started, how often it was required and when it ended	
				Past	Current

4. Declaration

a) I declare that all information declared above are true and complete, including those answers that are not in my own handwrit ing. 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 contract between Allianz Insurance Lanka Ltd. and me, and that any false, incorrect or misleading state ment may render this insurance null and void.

b) I understand to inform Allianz Insurance Lanka 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 that 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 Allianz Insurance Lanka Ltd, if it considers it appropriate, will check statements 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 subjected to the standard policy terms, exceptions and conditions effective at the time of policy commencement. I confirm that I have read and understood the full definitions, benefits, exclusions and conditions of this policy including the exclusions relating to pre-existing conditions.

Are you, or any of your immediate family members or close associates, a Politically Exposed Person (PEP)? ☐ Yes ☐ No

5. Data Verification Consent Clause

I/We hereby grant my/our consent and authorize Allianz Insurance Lanka Limited to verify the authenticity of the particulars relating to me/us as holder/holders of National Identity Card/s via the information system of the Department of Registration of Persons or any other validation method/system as applicable from time to time.

YES ☐

6. Service and Communication Consent

I/We hereby agree to receive via SMS and/or via e-mail to mobile number and/or email address provided by me/us here in above respectively for any digital marketing purpose/s and communication relevant information including special promotional offers of Allianz Insurance Lanka Limited.

YES ☐

Should you wish to withdraw your consent please do so by visiting below link.
https://digitalcustomer.allianz.lk/

7. Data Privacy

Please ensure to go through the Privacy Notice (i.e., which explains how and what type of personal data will be collected, why it is collected and to whom it is shared or disclosed etc.) which is available on the Allianz Insurance Lanka Limited official website https://www.allianz.lk/data-privacy-notice.html prior to signing of this form/ application/ document.

Signature of proposer	Date

*Allianz Insurance Lanka Limited is licensed by the Insurance Regulatory Commission of Sri Lanka (IRCSL).

Classification: Internal