Travel

NEPAL INSURANCE COMPANY LTD.

Issuing Office: Head Office, NIC Building, Kamaladi
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PROPOSAL FORM FOR OVERSEAS MEDICLAIM & TRAVEL INSURANCE POLICY
(Business & Holidays)

1.	Name of the Proposer(s) (as stated in Passport)	:
	(a) Person to be Insured	(i)
		(ii)
		(iii)
2.	Home Address	:
	Telephone No.	
3.	Proposer's actual occupation	:
4.	Office Address	:
	Telephone No	
5.	Age in Complete years:	(i)
	Height & Weight	(ii)
		(iii)
6.	Passport No.	:
7.	Plan opted for :	A, B, C - D, E, F, G
		(i) Excluding Canada & USA
		(ii) Including Canada & USA
8.	Purpose of visit	:
9.	Proposed day of departure from Nepal	:
10.	Insurance required for (Number of days)	:
11.	Countries to be visited (approximate number of days at each place)	:

12. Name Registration, address and telephone no. of family doctor :

13. Please answer the following question with 'Yes' or 'No' only.

a) Are you in good health free from Physical and Mental disease of infirmity : Yes ☐ No ☐

b) Have you ever suffered from any illness or diseases upto the date of proposing the proposal : Yes ☐ No ☐

c) Do you have any physical defect of deformity : Yes ☐ No ☐

d) Have you ever been admitted to any Hospital / Nursing home / Clinic for treatment or observation : Yes ☐ No ☐

e) If any answer is 'Yes' to any of foregoing question please give full particulars : Yes ☐ No ☐

f) Please give details of any knowledge of any positive existence of any ailment, sickness or injury which may require medical attention whilst on tour to abroad

I have declare that :-

1) I will not be travelling against the advice of a physician.
2) I am not on the waiting list for any medical treatment.
3) I will not be travelling for the purpose of obtaining medical treatment.
4) I have not received a terminal prognosis for a medical condition before this day.

ASSIGNMENT :

I _____ do hereby assign the monies payable under the policy in the event of my death to _____ relation and declare that his / her receipt shall be sufficient discharge to the company.

I declare and warrant that the above statement are true and complete. I consent to the insurance seeking medical information from any doctor who has at anytime attended concerning anything which affects my physical or mental health and authorize the giving of such information to **Specialty Assistance Services (SAS)** and/or **Medical Advisor**.

I agree that this proposal shall be the basis of the contract and willing to accept the policy subject to the terms, conditions and exceptions as prescribed therein.