সাধারণ বীমা কর্পোরেশন

SADHARAN BIMA CORPORATION

Head Office: SADHARAN BIMA CORPORATION, 33 Dilkusha Commercial Area, Post Box No- 607, Dhaka-1000.
Fax N0- 88-02-9564197, E-mail : info@sbc.gov.bd, Web site : www.sbc.gov.bd

PROPOSAL FORM FOR OVERSEAS MEDICLAIM POLICY (BUSINESS AND HOLIDAYS)

(To be submitted in original with two copies)
(Available to persons in the age group 6 months to 79 years)

THE OVERSEAS MEDICLAIM POLICY PROVIDES INDEMNITY FOR EXPENSES INCURRED FOR MEDICAL TREATMENT TO THE INSURED PERSON WHO TRAVELS ABROAD AS CORPORATE CLIENT, FOR ILLNESS, DISEASES CONTRACTED OR INJURY SUSTAINED DURING OVERSEAS TRAVEL AND WHICH IS PRIMARILY IN THE NATURE OF AN EMERGENCY AND WHICH IS NECESSARY TO BE UNDERTAKEN IMMEDIATELY, WITHOUT WHICH THE PROPOSER IS NOT ABLE TO LEAVE THE OVERSEAS COUNTRY UNDER MEDICAL ADVICE. THE ATTENTION OF THE PROPOSER IS DRAWN TO ITEM II (MEDICAL HISTORY) OF THE PROPOSAL FORM, ESPECIALLY IN RELATION TO PREVIOUS TREATMENT OF ILLNESS BY THE PROPOSER

THE PROPOSAL FORM SHOULD BE COMPLETED TO THE BEST OF YOUR KNOWLEDGE AND BELIEF AND ALL MATTERIAL FACTS * SHOULD BE DISCLOSED. FAILURE TO DO SO MAY NULLIFY COVER UNDER ANY POLICY ISSUED.

* A material fact is one that is likely to influence the Insurer's acceptance or assessment of the proposal. You should consult Corporation/ Company if you are in any doubt as to what constitutes a material fact.

I

1. Name and status of the proposer (in block letters) as stated in the passport
   State whether Mr./ Mrs./ Miss/ Master :
2. Residence address :
3. Residence Telephone No. or Mobile No. :
4. Proposer's Occupation (specify) :
5. Office Name and Address, if any :
6. Office Telephone No. :
7. Date of Birth (Age) :
8. Passport Number (copy attached) :
9. Plan Type :

Schengen Countries	**Non-Schengen Countries**
Worldwide (excluding USA & Canada) Plan A ☐	Worldwide (excluding USA & Canada) Plan A ☐
Worldwide (including USA & Canada) Plan B ☐	Worldwide (including USA & Canada) Plan B ☐

10. Purpose of Trip (State official / holiday travel in conducted tour/ holiday travel individual) :
11. Purposed date of departure from the People's Republic of Bangladesh (kindly note that no extension can be granted) :
12. Number of days stay outside the People's Republic of Bangladesh (kindly note that no extension can be granted) :

13. Itinerary (State countries and places to be visited and approximate number of days at each place :

14. Name and Address of the usual physician and Registration No. :

15. Telephone No. Consulting Room/ Office/ Residence :

II. MEDICAL HISTORY
TO BE COMPLETED BY THE PROPOSER / SPOUSE

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES OR NO (A DASH IS NOT SUFFICIENT AND GIVE FULL DETAILS.

1. Are you in good health and free from physical and mental disease or infirmity? : _____

2. Have you ever suffered from

(a) Any nervous, mental or psychiatric disease, slipped disc or other spinal disorder, fainting episode, blackout, fit or paralysis of any kind? :_____

(b) High blood pressure, heart diseases including ischemic heart disease, piles, varicose veins, other circulatory disorders or rheumatic fever? : _____

(c) Hernia, any rheumatic or joint disease Urinary disease or diabetes? : _____

(d) Any respiratory or allergic disease, or any disorder of the stomach, bowel or gallbladder? : _____

(e) Any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations? : _____

(f) Any complaint or tendency that may necessitate such consultation or treatment in the future? : _____

3. Are there any additional facts affecting the proposed insurance which should be disclosed to Insurers? : _____

4. Have you any intention of engaging in winter sports or pastimes rendering you liable to personal injury? : _____

5. Give particulars of any other illness or disease or accident sustained by you during the 12 months preceding the first day of Insurance in the table below.

Nature of illness/ disease Injury and treatment received	Date First Treated	Name of attending medical practitioner/ surgeon with his address and telephone Number
1.		
2.		
3.		
4.		

1. Please give details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention whilst on tour abroad.

   1.
   2.
   3.
   4.

I HEREBY DECLARE THAT

1. I will not be travelling against the advice of a physician.
2. I am not on 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.

I further declare and warrant that the above statements are true and complete. I consent to the insurers seeking medical information from any doctor who has at any time attended concerning anything which affects my physical or mental health, and I authorities the giving of such information as **INTANA GLOBAL** or their Program Medical Advisor may require. I agree that this proposal shall form the basis of the contract should the insurance be effected.

I am willing to accept the Policy, subject to the terms, exceptions and conditions prescribed by Corporation/ Company therein.

Signature _____ Date : _____/ _____/ _____

DD MM YY

Place_____

List of Schengen Countries

Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Italy, Greece, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Estonia, Latvia, Lithuania, Poland, Czech Republic, Slovakia, Hungary, Slovenia, Malta, Cyprus, Switzerland and Liechtenstein

OVERSEAS MEDICLAIM POLICY (TRAVEL INSURANCE) PRODUCT BENEFITS & LIMITATIONS	
01. Medical Expenses & Hospitalization abroad	US$ 50,000 Excess USD 100 (worldwide excluding USA / Canada.
02. Medical Expenses & Hospitalization abroad	US$ 100,000 Excess USD 100 (worldwide including USA / Canada
03. Medical Expenses and Hospitalization abroad for Schengen countries	Euro 30,000 with Nil deductible
04. Transport or Repatriation in case of illness of Accident	Actual Expenses
05. Emergency Dental Care	US$ 500, Excess US$ 50
06. Repatriation of Family Medical Travelling with the insured	Actual Expenses
07. Repatriation of mortal remains	Actual Expenses
08. Travel of one Immediate family member	US$ 100 per day, Maximum US$ 1,
09. Emergency return home following death of a close family member	Actual Expenses
NOTE: THE COMPANY WILL NOT BE LIABILE TO PROVIDE ANY ASSISTANCE WHICH ARISES DIRECTLY OR INDIRECTLY FROM ANY PRE—EXISTING MEDICAL CONDITION, SUICIDE OR ATTEMTED SUICIDE, MENTAL ILLNESS, PREGNANCY OR CHILDBIRTH	