SHARJAH INSURANCE COMPANY

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PROPOSAL FORM & DECLARATION OF HEALTH
TERM LIFE ASSURANCE

Full Name _____

Date & Place of Birth : _____

Address : _____

Tel. No. (Office) : _____ **Res:** _____ **P.O. Box No.** _____

Occupation :

Sum Assured : _____

Assurance Period : _____

Commencement Date : _____

OPTIONAL ADDITIONAL BENEFIT

- ☐ **Accidental Death Benefit**…….. **Amount** _____
- ☐ **Permanent Partial Disability (Accident)** …… **Amount** _____
- ☐ **Permanent Total Disability (Accident)**……... **Amount** _____
- ☐ **Permanent Total Disability (Sickness)**…… **Amount** _____
- ☐ **Temporary Total Disability (Accident) Weekly Salary** ……..…... **Amount** _____
- ☐ **Medical Expenses (Accident)**…… **Amount** _____
- ☐ **Waiver of Premium**…… **Amount** _____

I hereby declare that my monthly income for the last 12 months exceeded: **Dhs.** _____

Do you have another Life Insurance Policy ☐ **Yes** ☐ **No**

If "Yes", please give particulars : _____

Mode of Payment _____

Deposit Paid along with this Proposal: _____

Benificiary in case of Death : _____

_____

	Yes	No
- **Has your weight varied during the last 6 months?**	☐	☐
- **Have you or your family ever suffered from**		
heart attack?	☐	☐
chest pain?	☐	☐
a stroke?	☐	☐
hypertension?	☐	☐
diabetes?	☐	☐
any disorder of the heart or blood vessels?	☐	☐
AIDS?	☐	☐
- **Are you a member ot the Armed Forces?**	☐	☐
- **Engage in flying other than as a fare paying passenger?**	☐	☐
- **Reside or travel outside the country of residence other than on holiday?**	☐	☐
- **Have you been incapacitated from work for more than one week a result of of injury or illness?**	☐	☐
- **Are you in a good health?**	☐	☐
- **has a proposal for life Assurance ever been declined by any Insurance Company or accepted at special conditions?**	☐	☐

- **If the anwer to any one of the above questions is "Yes", please give details**

_____

_____

Health Declaration

Height _____ **Weight** _____

Health history for the last five years (including maternity if applicable)

Operation/Sickness	Treatment Period	Date	Physician

I declare that to the best of my knowledge and belief, the above and overleaf statements are true and I agree that they shall be the basis of the assurance on my life under ths above Scheme. I consent to the Sharjah Insurance Company, seeking medical information from any doctor, who at any time, has attended me concerning anything which affects my physical or menthal health, or seeking informa - tion from any insurance office to which a proposal has been made for insurance on my life, and I autorize the giving of such information. The Insurance shall not be valid, unless I pay the premium and receive the policy.

Signature of Proposer : _____

Signature of Agent : **Date :**

FOR OFFICE USE ONLY

Agent's Report

1. **Do you know the life assured?** _____
2. **For how long?** _____
3. **When was the last time that you saw him?** _____
4. **Is the life assured a relative of yours?** _____
5. **The last time seen, was he in good health?** _____
6. **Do you know if he was ill previously?** _____
7. **Do you have any interest - other than your work duty - to have an insurance for him?** _____
8. **What is the purpose of the insurance?** _____
9. **What is your estimation of the Assured's Income?** _____
10. **Do you recommend us to insure him?** _____
11. **Do you have any other information that will make us decline this application?** _____

Name of the Agent : _____

Signature of the Agent : _____

Date : _____

REFERENCES

Name	Phone No.	Occupation	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____