



شركة وربة للتأمين ش م ك
WARBA INSURANCE COMPANY K.S.C.

PROPOSAL & HEALTH DECLARATION FORM FOR AROGYAM HEALTH
INSURANCE POLICY

PROPOSER/MAIN MEMBER DETAILS

Name of the Insured in full (As in the Passport)			
Age		Marital Status	
DOB		Nationality	
Gender		Civil ID No.	Passport No.
Occupation & Name of Employer			

CONTACT DETAILS

Address in Kuwait			
Tel. No.		E-mail:	
Address in India			
Tel. No.		Emergency Contact	
Period of Insurance required			

DETAILS OF MEMBERS TO BE INSURED

Name of Insured	DOB & Age	Marital Status	Gender	Relation	Sum Insured Opted

Previous Policy Details

Any of the member(s) has any health insurance coverage		Yes ()	No ()
If Yes Provide- Insurance Co.		Policy No. _____	
Please give details of claims lodged under previous policy _____			
Has proposal for any member been declined by any insurer		Yes ()	No ()
Are there any other relevant facts to be disclosed to insurer _____			



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MEDICAL HISTORY OF THE MEMBERS TO BE INSURED

If you are suffering or have previously suffered from any of the following disease or had medical complaints, please give details of duration & treatment taken after mentioning Yes/No

	Main Member	Member 2	Member 3	Member 4	Member 5	Member 6	In case Yes Give details seperately
NAME							
Diabetes							
Hypertension and/or Heart Diseases/Complaint							
Respiratory Diseases/Asthama							
Allergies							
Gynecological Disorder							
Orthopaedic/Spinal Complaint							
Neurological Disorder							
Psychiatric Disorder							
Impairment of Vision/Cataract							
Malignancy							
Piles, Hernia, Varicose Veins, Sinusitis, Stones (Ureter/kidney/gall Bladder), Complaint of prostate							
Congenital defects/diseases							
Any other illness/disease/complaint/symptoms/injury							
Underwent any Surgery							
Taken medical Consultation, Treatment or Test in connection with Aids, Aids related conditions, Hepatitis B or any sexually transmitted diseases							

I _____ do hereby declare that the above personal, insurance & medical information given by me about myself and my family members are true to the best of my/their knowledge and facts. I agree that this declaration and the information given above shall be the basis of the contract between me/us & the insurer and if there be any false statement or concealment of the truth in this declaration or in such answers, the insurance shall be null and void and all the benefits under the policy shall be forfeited. We give our consent and authorize the insurer/TPA/their representatives to see Medical Information from any Hospital/Medical Practitioner who has at any time attended any injury, illness which affects my physical, medical condition.

Date: _____

Place: _____

Main Member/Proposer's Signature

Note: Please submit 2 photographs each for the members to be covered under the policy, clearly mentioning their Name & Age on the back side.