



THE NEW INDIA ASSURANCE COMPANY LIMITED
MUSCAT
BETTER HEALTH - GROUP MEDICAL INSURANCE
PROPOSAL FORM

1. Company Information

- Company Name
- Company Business or Activity..... Contact Person... ..
- Address
- Telephone Number Telefax

2. Persons eligible for insurance

- How many people does your company or organisation employ ?
- Do you wish to insure all of these employees ? **YES** **NO**
- If you do not wish to cover all the above employees which classes of employees do you wish to cover
i.e. Senior Management, Middle Management, Junior Staff etc.

Please show the categories on the Group Census Information

3. Type of enrolment

- | | YES | NO |
|---|--------------------------|--------------------------|
| • In the classes of employees, which you wish to cover, will all eligible persons be enrolled ? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Will eligible persons themselves have the choice whether to enrol or not ? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you wish to cover the spouses and children of eligible persons ? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Will eligible persons pay any part of the cost of this insurance themselves? | <input type="checkbox"/> | <input type="checkbox"/> |

4. Previous insurance or company paid healthcare benefits

- | | | |
|---|--------------------------|--------------------------|
| • Are you now or have you previously been insured for healthcare benefits ? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has your company provided healthcare benefits itself or funded them itself ? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Please provide the information as per the Group Census Information for the last 3 years including the current year regarding previous insurance or company provided/funded healthcare benefits. | | |

5. Details of persons to be covered

Please provide us with details of the persons to be covered on the attached Group Census Information.

6. Declaration

We hereby apply for a group healthcare insurance and declare that to the best of our knowledge and belief the information given is true and complete. We hereby undertake to immediately notify New India Assurance Co., Muscat of any change to the information declared above.

We have not withheld or misrepresented any material fact and we agree that if a contract of insurance is effected all information submitted in connection with this application shall be the basis of the contract between us and New India Assurance Company Ltd., Muscat

We understand that only persons declared on the group census will be covered by the policy and that this application is subject to approval and acceptance by New India Assurance Company Ltd., Muscat

Signature of Authorised Person Of The Company

NAME: _____

DATE: _____

POSITION HELD: _____



**BETTER HEALTH - GROUP MEDICAL INSURANCE
EMPLOYEE CENSUS INFORMATION**

Please enter the details of persons to be insured:

CATEGORY OF EMPLOYEE :					
AGE-GROUP	MALE EMPLOYEES	FEMALE EMPLOYEES	MALE SPOUSES	FEMALE SPOUSES	CHILDREN
0-20					
21-40					
41-50					
51-60					
61-65					
TOTAL					

If there is more than one category of employee to be covered please enter the details on a separate sheet. A photocopy of this page can be used.



Details Of Previous Insurance Benefits
 OR
 Details Of Previous Company Paid Medical Benefits

	YEAR	YEAR	YEAR
	2004	2005	2006
Insurer			
Number Of Persons Covered			
Number Of Claims Paid			
Total Amount Of Claims Paid			
Number Of Claims Outstanding			
Total Amount Of Claims Outstanding			
Deductible under the Policy			
Total Premium Paid			
Major Claims - Please give full details of any major claims			