



The New India Assurance Company Limited

P.O.Box 2907, Ruwi, PC 112, Sultanate of Oman
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TRAVEL INSURANCE PROPOSAL FORM

I. GENERAL INFORMATION:

1. NAME OF THE PROPOSER :
(IN BLOCK LETTERS)
AS STATED IN THE PASSPORT
2. ADDRESS & TELEPHONE NO. :
3. PROPOSER'S ACTUAL OCCUPATION :
4. DETAILS OF MEMBERS TRAVELLING :

SR. NO.	NAME	RELATION SHIP	DATE OF BIRTH	NATIONALITY	PASSPORT NO.	RESIDENT CARD / ID NO.

5. PLAN OPTED FOR :
A (EXCLUDING USA & CANADA)
B (INCLUDING USA & CANADA)
6. PURPOSE OF VISIT :
(BUSINESS / HOLIDAY TRAVEL)
7. PROPOSED DATE OF DEPARTURE :
FROM SULTANATE OF OMAN,
I.E. FIRST DAY OF INSURANCE
8. INSURANCE REQUIRED FOR :
(NUMBER OF DAYS)

N.B. : 1. In case of any extension of stay abroad, requiring extension of Policy period, approval of issuing office has to be obtained and appropriate premium paid before expiry of Policy. Request for such extension should be supported with a declaration of good health.

9. COUNTRIES TO BE VISITED :
(STATE APPROXIMATELY NUMBER
OF DAYS AT EACH PLACE)
10. NAME, REGISTRATION NO. :
ADDRESS & TELEPHONE NO.
OF FAMILY PHYSICIAN

MEDICAL REPORTS ARE REQUIRED:

- A) Trip is for period over 60 days and if
 - a) Insured person if over 60 years of age visiting USA/CANADA.
 - b) Insured is over 65 years of age and visiting Countries other than USA/CANADA
- B) Proposal reveals that Insured had suffered from / suffering from any illness / disease.

The Proposal form should be accompanied with 1) ECG printout with report and 2) Fasting Blood Sugar and Urine Sugar Urine Strip Test Report or any other medical report required by the Company etc along with the attached questionnaire to be completed and signed by the Doctor with minimum M.D. qualifications conducting the test.

II MEDICAL HISTORY:

A. TO BE COMPLETED BY THE PROPOSER :
PLEASE ANSWER THE FOLLOWING QUESTIONS WITH '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 any illness or Disease upto the date of making this Proposal:
3. Do you have any physical defect or deformity :
4. Have you ever been admitted to any Hospital / Nursing Home / Clinic for treatment or observation
5. Have you suffered from any illness / disease or had an accident in the 12 months preceding the first day of insurance
6. If the answer is 'Yes' to any of the foregoing questions, please give full details as under:

Nature of Illness / disease / injury & treatment received	Date on which first treatment taken	First Treatment completed / is continuing	Name of attending medical practitioner / surgeon with his address & Tel.Nos.

7. a) Have you any intention of engaging in professional sports ?
b) If so, give details :
8. Please give details of any knowledge of any positive existence of any ailment, sickness or injury which may require medical attention whilst on tour abroad.

I HEREBY DECLARE THAT

1. I will not be travelling against the advices of a physician.
2. I am not on the waiting list of 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 my (relation to the Insured) Mr. / Mrs. / Miss / Master..... I further declare that his her receipt shall be sufficient discharge to the company.

I further declare that 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. 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 therein.

Signature of the Proposer :

Date :

Place :